APOLLO GENETICS
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PATIENT ASSISTANCE PROGRAM & APPLICATION

After careful review, your healthcare provider determined that genetic testing by Apollo Genetics Laboratories is necessary. Apollo Genetics abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. Apollo Genetics recognizes that circumstances may arise where an individual is unable to pay. We adopted a process of screening requests for delayed payment plans, discounts, or forgiveness of debt based on individual circumstances. This patient assistance program is our commitment to work with patients and assure that necessary genetic testing can be provided at a reasonable cost for those with a financial need or for those who are under insured. Apollo Genetics will calculate your financial need based on your annual adjusted gross income and the number of family members in your household.

Program Requirements

If you meet the following criteria, please complete this form, and provide supporting documentation.

___ Patient has healthcare insurance, received a bill, and needs financial assistance.

___ *Patients with U.S. federal or state funded health insurance (Medicare, Medicaid) should not use this form.*

Family Size (Excluding current pregnancy)	Combined Family Income Equal to or Less Than*
1	$49,960
2	$67,640
3	$85,320
4	$103,000
5	$120,000
6	$138,360
7	$156,040
8+	$173,720

Patient Information

______________________ ______
Patient Last Name MI

______________________ ______
Patient First Name Date of Birth

____
Address

__________ ______ ______
City State Zip

____
Email

____
Primary Insurance Company Name

______________________ ______________
Total Annual Gross Household Income Number in household

____
Test Code Ordered

* Patient assistance is based on the 2019 Federal Poverty Income Sliding Scale. Combined household income must be less than or equal to four times the federal poverty guidelines. This is based on the HHS Poverty Guidelines. Restrictions may apply.

Attestation

I hereby certify that the information provided by myself, or my legal representative is true and accurate. I have read and understand the Apollo Genetics Patient Assistance Program requirements. I understand and agree that Apollo Genetics reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to verify the information I provide on this application. I further certify and agree that I will not seek reimbursement or credit for this testing from any insurer, health maintenance organization, government program or other source of financial assistance. I understand that if I do not qualify, I will be notified. I acknowledge that I am neither related to, nor employed by, the healthcare provider ordering the genetic tests. Apollo Genetics can require the patient to pay full price if it later determines that inaccurate information was provided.

______________________________ ______________
Signature of Patient or Legal Representative **Date**

Examples of Supporting Documentation

- Copy of Most Recent IRS 1040 Tax Form
- Earnings From Work - Last 2 Paycheck Stubs
- Unemployment Payment Information
- Social Security Disability or Survivor Benefits
- Child Support Statement
- Proof of Bankruptcy Settlement
- Catastrophic Situations (Death or Disability)
- Other Doc Showing Inability to Pay

OFFICE USE ONLY

_____ APPROVED _____ DENIED

__________ ____/____/____
Initial Date