Return Information to:

MAIL: Pro-GeneX Financial Assistance

999 Chestnut ST SE STE 16 |

Gainesville | GA 30501

PHONE: (844) 794-3637

EMAIL: Marcie.Swenson@pro-genex.com

Financial Assistance Application

Instructions for completing this form:

Please fill this form out completely and return all required documentation to the address or email listed above. Financial assistance will not be awarded to those who do not complete the application process; including the requirement for the patient to apply for programs for which they may qualify (i.e. Medicaid).

Please submit the following documentation:

- 1. Copies of your current federal tax return with all schedules, including W-2s
- 2. Household income verification noted below

Patient Name		Account N	Account Number			Birth Date				
Responsible Party Name			Social Security Number			Birth Date				
Relationship to Patient	Home	Home Phone			Cell Phone					
Address				City			StateZip			
Employer Name						Work Phone				
How long have you lived atthis add Please list addresses for the	ress?	YearsMonths								
Address		City	City		Zip	From	(Month/Year)	To (Month/Year)		
Spouse Name	•	Spouse Social Security Number			Spouse Birth Date					
Spouse	Spouse Cell Phone			Spouse Employer Nam <u>e</u>						
Additional Household Member	ers									
Name	Birth Date	Relationship		Name Bir		Birth Date	Relationship			

Household Monthly Income

If you are unable to provide copies of the verified information; please provide 3 months bank statements with an explanation on the back of this form						
Туре	Responsible Party Amount	Spouse Amount	Type of Income Verification Required			
Employment Income (Gross)	\$	\$	☐ Provide paycheck stubs for the last two pay periods or 3 months bank statements			
Self-Employment Income (Gross)	\$	\$	☐ Provide 3 months bank statements			
Pension, Retirement, Social Security Income	\$	\$	☐ Provide your Pension/Retirement statement, and/or Social Security award letter			
Unemployment, Disability Income, etc. Check if Disabled/unemployed longer than 6 months	\$	\$	☐ Provide unemployment, disability award letter, or 3 months bank statements			
Child Support, Alimony	\$	\$	☐ Provide a copy of your divorce decree, legal separation notice, or custody agreement if you would like this information considered			
Other (Please list source):	\$	\$	☐ Provide 3 months bank statements with an explanation of your income source(s)			

We ask patients who apply for financial assistance to look for or	ther funding also. Please check "Yes" or "No".
Does your employer or spouse's employer offer group health insurance? Do you have other types of insurance such as Allstate, AFLAC, etc.? Do you have a Health Savings / Flex Spending Account?	Yes ☐ No If yes, list insurance company:Yes ☐ No If yes, list insurance company:Yes ☐ No If yes, list balance amount: \$
Does your employer reimburse you for any deductible or healthcare costs?	□ Yes □ No
Were you denied for Medicaid? Please attach a copy of the Medicaid denial. you applied for state assistance programs (CHIP, PCN, Crime Victims, etc.)? eligible for COBRA through a previous employer?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Do you have family or church assistance?	☐ Yes ☐ No If Yes, please provide details below.
Please explain any situation we should be informed of in order to ou may attach a separate sheet if more space is needed. Additio	
hereby state that the information given herein is true and correct. I a bureau report. I understand that if this information is determined to be for all services rendered. I understand that this request for financial as	false or deceptive, I will be liable for payment of charges
Responsible Party Signature	Date
Checklist of all required information t ☐ Front and back of form filled out completely with signature and date ☐ Copies of your current federal tax return with all schedules including ☐ Household income verification	