



Financial Assistance Application

Patient/Recipient Information

Patient full name:

Date of Birth:
month day year

Sex:

Social Security Number:

Parent/Guardian:
(if applicable)

Address:

City: **State:** **ZIP/Postal Code:**

Email:

Day Phone:

Alternate Phone:

Fax:

Emergency Contact Name:
(not living at above address)

Emergency Contact Phone:

In order to help us assess financial need, determine your eligibility for financial assistance by Everist Genomics and select the program that best fits your needs, please tell us about yourself by answering the following questions:

Are you currently employed? YES NO

Total average monthly income: \$

Total average monthly expenses: \$

(including automobile loans, revolving charge accounts, real estate loans, alimony, child support, utilities and grocery expenses)

Total number of dependents:

(including spouse and children under 21 years of age)

Estimated total assets: \$

(including cash, stocks, bonds)

Do You Have Medicare Coverage? YES NO

Medicare Number:

Do You Have Medical Insurance Coverage? YES NO

If you answered 'YES' to either the Medicare or Insurance coverage questions above, please also complete and submit the **EVERIST GENOMICS ASSIGNMENT OF BENEFITS** form which is provided separately.

AUTHORIZATION

Acknowledgement. The undersigned hereby acknowledges that Everist Genomics Inc., may verify any information contained in this form or obtain any information or data relating to this form, for any legitimate business purpose through any source, including a consumer reporting agency.

Signature _____ Date _____