

## Genomind Patient Assistance Program Application

### Instructions

Patients who have an annual family income of 400% federal poverty level (FPL) or less may receive the Genomind® PGx test at a reduced price based upon a sliding fee schedule. Please complete all sections of the application and send with proof of income to [billing@genomind.com](mailto:billing@genomind.com) or fax to 855-454-4900. This application does not replace the need for the Genomind Test Requisition Form. Please contact Genomind at 877-895-8658 with any questions relating to Patient Assistance. Applications will be approved within 5 business days, and applicants will be contacted via email. Payment will still be due prior to processing the sample.

**Important:** If acceptable proof of income is not included with the application, the application will not be approved. Acceptable proof of income documents includes tax documents (1040 form) from prior year or government assistance letters (social security benefit verification letter or unemployment letter). No other documentation will be accepted.

### Patient information

Patient name: \_\_\_\_\_ Patient date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of person completing application: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
*If someone other than the patient is completing application:*  
 Home address line 1: \_\_\_\_\_ Apt \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Test requisition number or Account number: \_\_\_\_\_

If your annual gross household income falls within the totals on the table at the bottom of this page, you may qualify for Genomind's patient assistance program based on the number of dependents in your household. For example, if you have two people in a household and your gross household income is \$21,000, you would qualify in the 200% FPL.

Household gross income: \_\_\_\_\_ # of dependents: \_\_\_\_\_

### Patient certification of financial hardship

My existing financial resources are not sufficient to cover the cost of the Genomind® PGx test. I am requesting to be included in the Patient Assistance Program. My household income falls below 400% of the Federal Poverty Level (FPL) as established by the U.S. Department of Health and Human Services. I certify that the information contained in this application is correct to the best of my knowledge. I have provided documentation to verify the information contained in this application (please provide 1040 tax form or government assistance letter). I will not seek reimbursement from any insurance carrier or government agency for fees waived.

Patient or guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 2022 Federal Poverty Guidelines Chart -- 48 Contiguous States and DC (excludes HI and AK)

Please circle family/household size and appropriate FPL

Persons in family/household	100% FPL	200% FPL	300% FPL	400% FPL
1	Less than \$13,590	\$27,180	\$40,770	\$54,360
2	Less than \$18,310	\$36,620	\$54,930	\$73,240
3	Less than \$23,030	\$46,060	\$69,090	\$92,120
4	Less than \$27,750	\$55,500	\$83,250	\$111,000
5	Less than \$32,470	\$64,940	\$97,410	\$129,880
6	Less than \$37,190	\$74,380	\$111,570	\$148,760

For families/households with more than 6 persons, add \$4,720 for each additional person.

**2022 Federal Poverty Guidelines Chart -- Hawaii***Please circle family/household size and appropriate FPL*

Persons in family/household	100% FPL	200% FPL	300% FPL	400% FPL
1	Less than \$15,630	\$31,260	\$46,890	\$54,360
2	Less than \$17,420	\$21,060	\$52,260	\$73,240
3	Less than \$21,960	\$26,490	\$65,880	\$92,120
4	Less than \$26,500	\$31,920	\$79,500	\$111,000
5	Less than \$31,040	\$37,350	\$93,120	\$129,880
6	Less than \$35,580	\$42,780	\$106,740	\$148,760

For families/households with more than 6 persons, add \$5,430 for each additional person.

**2022 Federal Poverty Guidelines Chart -- Alaska***Please circle family/household size and appropriate FPL*

Persons in family/household	100% FPL	200% FPL	300% FPL	400% FPL
1	Less than \$16,090	\$33,980	\$50,970	\$67,960
2	Less than \$22,890	\$45,780	\$68,670	\$91,560
3	Less than \$28,790	\$57,580	\$86,370	\$115,160
4	Less than \$34,690	\$69,380	\$104,070	\$138,760
5	Less than \$40,590	\$81,180	\$121,770	\$162,360
6	Less than \$46,490	\$92,980	\$139,470	\$185,960

For families/households with more than 6 persons, add \$5,900 for each additional person.