# Financial Assistance Program Application

**Phone: 877-436-3894**
**Submit this signed application to: Armune Financial Assistance Program**
**401 W. Morgan Rd, Ann Arbor, MI 48108**
**Or Fax to: 949-222-5019 Or email to: customerservice@armune.com**

| Patient Information |
|---|
| Name (Print First & Last): |
| Address (Number & Street Name,<br>City, State, Zip Code): |
| Phone Number(s): |
| Date of Birth (MM/DD/YY): |
| Account Number (from billing statement): |

| Health Insurance/Other Assistance |
|---|
| Are you covered by any of the following? (Check all that apply) |
| ☐ Medicare ☐ Medicaid ☐ Health Ins ☐ Cancer Program ☐ VA ☐ None (Uninsured) |

A patient may not be eligible for FAP participation in certain federally funded programs

| Total Gross Yearly Income | | Household Size | |
|---|---|---|---|

| **If no income, please explain** | |
|---|---|
| | |
| | |

| **Household Income Guidelines** | **Out of Pocket Amount** |
|---|---|
| $50,000 or less | $50.00 |
| > $50,000 to $75,000 | $100.00 |
| > $75,000 to $100,000 | $200.00 |
| > $100,000 responsible for all copays, coinsurance and deductibles and any patient responsibility up to the the full cost of the test. | |
| **Eligibility Requirements:** | |
| • Must be a US Citizen or resident | |
| • Completed application with signature | |
| • Proof of income (a recent tax return, pay stub, W2, unemployment or disability statement etc) | |

| **Certification** | | |
|---|---|---|
| I certify that the above information is correct to the best of my knowledge. I authorize the release of any of this information from my employer and/or holders of this information, for the purpose of evaluating assistance in the payment of my medical bills and verification of my income. | | |
| **Patient /Guarantor signature** | Date | |