Patient Financial Assistance Application

Freenome

For patients or their authorized representative

Use this form to apply for financial assistance that may reduce or eliminate eligible out-of-pocket costs for Freenome testing. Complete all required fields. Applying does not guarantee approval.

Please email completed form to: support@freenome.com

1. Patient Information

Patient full name | **Required**

Date of birth | **Required**

Street address | **Required**

City | **Required**

State | **Required**

Zip | **Required**

Phone | **Required**

Email | **Required**

Preferred contact: ○ Phone ○ Email ○ Mail

By providing my telephone number, I agree to receive automated text messages from Freenome about my laboratory services, including test-related communications, billing, insurance, payment options, and financial assistance. Message and data rates may apply.

2. Freenome Test and Provider

Test/Order no. (if known)

Ordering provider (if known)

Practice or facility (if known)

Provider phone or email, if known (No need to list each order number.)

3. Insurance (if available)

Health insurance information available? ○ Yes ○ No

Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company

Member/ID

Policyholder

4. Current Household Income

Household size means the number of people supported by this income. Include gross wages or salary, unemployment, disability or workers' compensation, Social Security/SSI, public assistance (including TANF/SNAP), and other income.

Household size (number of people) | **Required**

Current annual gross income before taxes | **Required**

$

Income recently changed? ○ Yes ○ No

5. Extenuating Circumstances | Optional

Check any that apply. Add details and amounts if helpful.

- ☐ Loss of income or disability leave
- ☐ Fixed income
- ☐ High out-of-pocket medical bills
- ☐ Significant debt tied to medical expenses
- ☐ Support for family outside household
- ☐ Non-local travel or lodging
- ☐ Emergency expense
- ☐ Natural disaster
- ☐ Charity care
- ☐ Other: _____
- ☐ None

If known, amount $ _____ or _____% of income

Additional details: what happened, when, and why it affects you:

6. Your Statement and Signature

I confirm the information in this application is true and complete. I allow Freenome to use it to review my request. Approval is not automatic. If approved, assistance may apply to eligible Freenome tests ordered before the award and within 18 months after the award. Freenome will send a written decision using my preferred contact method.

○ Patient ○ Authorized to sign for patient

Signature | **Required**

Application date | **Required**

Printed name/Relationship