Genomic Unity® Testing

Variantyx Patient Assistance Program

Variantyx is dedicated to making genetic testing affordable and accessible to everyone with a medical need. For patients with commercial insurance who qualify for our Patient Assistance Program, out-of-pocket expenses are limited on a sliding scale based on household size and adjusted annual income relative to Federal Poverty Guidelines. For self-pay patients and those who do not qualify for the Patient Assistance Program, flexible payment options are available. Due to regulatory restrictions, beneficiaries of government-funded programs (e.g., Medicaid, Medicare, TriCare, Veterans Affairs) are not eligible to apply.

Patient Information

Last Name _____ First Name _____ MI _____ DOB (MM/DD/YYYY) _____ Sex ☐ F ☐ M

Street Address _____ Apt # _____ City _____ State _____ Postal code _____ Country _____

Phone _____ Email _____

Preferred method of contact ☐ Phone ☐ Email ☐ Mail

Household Size and Annual Adjusted Income Details *(fields in this section marked with an asterisk (*) are required to assess eligibility)*

☐ *** Number of family members in household supported by gross annual household income (including the patient)**
Must be filled out to process form

* Estimated Annual Household Gross (Pre-Taxed) Income

_____

Estimated Household Annual Housing Expense (primary residence only)
(e.g., out-of-pocket rent, mortgage, rental/ home insurance, property taxes)

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Estimated Household Annual School Tuition/ Childcare and/or Eldercare Expense *(e.g., eligible tuition expenses are net of scholarships, tuition waivers and/ or discounts; childcare includes out-of-pocket daycare, afterschool programs, and/or day camp expenses; eldercare includes out-of-pocket nursing and supportive care expenses)*

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Estimated Household Annual Automobile/ Transportation Expense *(e.g., eligible expenses include car payments, car maintenance costs, and/or non-reimbursed public ground transportation for work or school)*

_____

Estimated Household Annual Medical Expense *(e.g., eligible expenses include out-of-pocket medical bills, and prescription drug costs)*

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Patient Must Provide Documentation

Variantyx must receive confirmation of adjusted annual household income before approving assistance. Adjusted annual income is pre-taxed value including the total wages, social security, pension/ retirement, and other forms of income for all members of the household.

Please provide the patient/ guardian's most recent federal tax return or last two pay stubs. If you are unable to submit proof of income documentation, briefly describe below your income source(s) and why your tax return and/or pay stubs are not available:

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I Hereby Acknowledge the Above Information is True and Correct:

I hereby certify that the information provided above and the documentation I provide to Variantyx are true and accurate. I understand and agree that Variantyx reserves the right, at any time and without notice, to modify the application form, to modify or terminate this program, to audit my information or to request additional information. I also certify that I do not carry any US federal or state-funded health insurance.

Patient Name OR Personal Representative (Print) _____ Signature _____

Relationship to Patient _____ Date _____

Return Signed Form To Attn: *Client Services*

Fax: 617-433-5024 Mail: 1671 Worcester Road, Suite 300 Framingham MA 01701