ANNIEGUARD

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Financial Assistance

Please complete all fields.

Typical form response time is 5-7 business days.
info@annieguard.com
p: +44 7520 643580
For immediate application results:
info@annieguard.com
p: +44 7520 643580

PATIENT INFORMATION

Last Name	**First Name**	**DOB (MM/DD/YYYY)**	**Biological Sex**
Address (Street, Unit)		**City**	**State**
ZIP	**Do you have health insurance?** ○ Yes ○ No		
Primary Method of Contact (Email Address)		**Secondary Method of Contact (Phone Number with Area Code)**	
Estimated Gross Annual Household Income: (REQUIRED - Numerical values only)		**Number of family members in household supported by the gross annual household income, including the patient (REQUIRED):**	
What insurance do you have?			

ORDERING PHYSICIAN & INSTITUTION INFORMATION

Institution (the name of the hospital or practice where you are being treated)
Ordering Physician's Name

EXTENUATING CIRCUMSTANCES

☐ Alimony and/or child support expenses > $1,000 per month
☐ Currently enrolled in short or long term disability with my employer ☐ None
☐ Non-local travel for treatment (e.g. hotel, airfare) > $1,000 ☐ Credit card debt > $5,000 ☐ Other: _____
☐ Supporting family member(s) outside of household ☐ Medical expense > $5,000
☐ Qualified for charity care with my physician ☐ Permanent loss of income due to diagnosis or treatment

Please share any background you would like our financial assistance team to take into consideration when reviewing your application:

CONSENT TO APPLICATION

☐ **Patient**

By signing and submitting this application, I am certifying that all information provided is truthful and complete and I understand that financial assistance may be withdrawn if the information is inaccurate. I also consent to AnnieGuard's use of the information to assess and/or verify eligibility for assistance.

☐ **Patient Representative**

As a Personal Representative of the patient, my signature certifies that (1) I have the right to do so on the patient's behalf, (2) if possible, I've explained to the patient the nature and purpose of this application, (3) the information set forth above is, to the best of my knowledge, truthful and complete, and (4) I consent to AnnieGuard's use of the information to assess and/or verify eligibility for assistance.

Full Name	**Phone**
Relationship to Patient	**Email**
Signature	**Today's Date (MM/DD/YYYY)**

By signing, you are indicating that all knowledge is correct to the best of your ability. If the provided information proves to be inaccurate, AnnieGuard reserves the right to revoke financial assistance.