

## Patient Assistance Support

### PATIENT AUTHORIZATION AND ATTESTATION FOR APPLICATION FOR ASSISTANCE:

I understand that my treating physician at Medical Oncology Hematology Consultants, and the Patient Assistance Support [PAS] department are acting solely as agents to help me find and apply for appropriate financial assistance, either in the form of free or reduced-cost treatment. The Patient Assistance Support team is affiliated with the oncology physicians in The US Oncology Network. I understand that there is no fee or charge for the support services provided by PAS.

I authorize Patient Assistance Support to use my information to complete phone, electronic or hardcopy applications and to sign online applications on my behalf to determine my eligibility. I understand that my physician and PAS do not determine my eligibility for assistance. Eligibility for assistance is determined by the sponsors of the charitable foundations or product manufacturers ("Programs") and is contingent upon the eligibility criteria set forth by the program.

By authorizing PAS to submit my application, I attest that I understand and agree to the below statements:

- All information I have provided, and will provide to Patient Assistance Support and to the Programs for my application, to the best of my knowledge is, and will be, true and complete.
- I understand that the Program sponsor may request documentation to verify the accuracy of any information that I provide for the application, including verification of my household income.
- If I do not provide documentation or information as requested by the Program, or if the Program determines I do not meet the Program eligibility requirements, my participation and all assistance may be terminated.
- I will notify Patient Assistance Support or the Program of any changes to the information I have provided.
- I am not receiving financial assistance for the same expenses for which I have applied.
- Agents at PAS and the Assistance Program can obtain and discuss medical, treatment, therapy, financial and other information relating to my application with my providers, pharmacy, insurance company, and to other organizations working on my behalf to obtain eligible treatment.
- The Program can at any time, and without notice, modify or discontinue all or any part of the Program and/or any assistance provided to me.
- The financial assistance or free product provided by any Program may not cover my entire liability for treatment. Some Programs limit assistance to the specific drugs that treat my cancer disease.
- This agreement is for the next 12 months. I can revoke this agreement at any time by providing a signed letter of revocation.
- Should additional assistance be needed for continuity of treatment, I understand that PAS will complete and submit applications to secondary Programs or submit renewal applications on my behalf.

**Annual Household Income:** \_\_\_\_\_ **Number in household dependent on income:** \_\_\_\_\_

**Income Source:** \_\_\_\_\_

**Potential Foundation(s)/ Federal Poverty Level:** \_\_\_\_\_

**Copay Card(s)/PAP:** \_\_\_\_\_

**Insurance plan(s):** \_\_\_\_\_

Patient's Name (print): \_\_\_\_\_ MRN: \_\_\_\_\_

Fax completed form to: 866.750.8766

\*See chart for income guidelines.

Physician: \_\_\_\_\_

Facility: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Drugs prescribed: \_\_\_\_\_

Check the statement below that applies to your situation:

\_\_\_\_\_ I have applied or have been approved for financial assistance for my treatment to the following foundations or patient assistance programs (please list and include any discount drug cards you may have):

\_\_\_\_\_ I have not applied for any assistance for my treatment at this time and understand that if I have applied elsewhere, I must disclose this to any other foundation or patient assistance program that approves me for funds or drug product.

I attest that the information provided in this document is complete and accurate. I agree and certify that I have read, understood and will abide by the above attestation and authorize Patient Assistance Support advocates to proceed with applying for assistance on my behalf.

Patient's Name (print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Patient Street Address \_\_\_\_\_

Patient Mailing Address (if different than above):

Phone Number: \_\_\_\_\_ MRN: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Deductible/Amt Met: \_\_\_\_\_ OOP Max/Amt Met: \_\_\_\_\_

Clinic Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Poverty Guidelines, all states (except Alaska and Hawaii)

2019 Annual

Household

| /Family Size | 50%    | *100%*   | 125%   | 130%   | 133%   | 135%   | 138%   | 150%   | 175%   | 185%   | 200%    | 225%    | 250%    | 300%    | 400%    |
|--------------|--------|----------|--------|--------|--------|--------|--------|--------|--------|--------|---------|---------|---------|---------|---------|
| 1            | 6,245  | \$12,490 | 15,613 | 16,237 | 16,612 | 16,862 | 17,236 | 18,735 | 21,858 | 23,107 | 24,980  | 28,103  | 31,225  | 37,470  | 49,960  |
| 2            | 8,455  | \$16,910 | 21,138 | 21,983 | 22,490 | 22,829 | 23,336 | 25,365 | 29,593 | 31,284 | 33,820  | 38,048  | 42,275  | 50,730  | 67,640  |
| 3            | 10,665 | \$21,330 | 26,663 | 27,729 | 28,369 | 28,796 | 29,435 | 31,995 | 37,328 | 39,461 | 42,660  | 47,993  | 53,325  | 63,990  | 85,320  |
| 4            | 12,875 | \$25,750 | 32,188 | 33,475 | 34,248 | 34,763 | 35,535 | 38,625 | 45,063 | 47,638 | 51,500  | 57,938  | 64,375  | 77,250  | 103,000 |
| 5            | 15,085 | \$30,170 | 37,713 | 39,221 | 40,126 | 40,730 | 41,635 | 45,255 | 52,798 | 55,815 | 60,340  | 67,883  | 75,425  | 90,510  | 120,680 |
| 6            | 17,295 | \$34,590 | 43,238 | 44,967 | 46,005 | 46,697 | 47,734 | 51,885 | 60,533 | 63,992 | 69,180  | 77,828  | 86,475  | 103,770 | 138,360 |
| 7            | 19,505 | \$39,010 | 48,763 | 50,713 | 51,883 | 52,664 | 53,834 | 58,515 | 68,268 | 72,169 | 78,020  | 87,773  | 97,525  | 117,030 | 156,040 |
| 8            | 21,715 | \$43,430 | 54,288 | 56,459 | 57,762 | 58,631 | 59,933 | 65,145 | 76,003 | 80,346 | 86,860  | 97,718  | 108,575 | 130,290 | 173,720 |
| 9            | 23,925 | \$47,850 | 59,813 | 62,205 | 63,641 | 64,598 | 66,033 | 71,775 | 83,738 | 88,523 | 95,700  | 107,663 | 119,625 | 143,550 | 191,400 |
| 10           | 26,135 | \$52,270 | 65,338 | 67,951 | 69,519 | 70,565 | 72,133 | 78,405 | 91,473 | 96,700 | 104,540 | 117,608 | 130,675 | 156,810 | 209,080 |