

FINANCIAL ASSISTANCE APPLICATION

STEP 1: PATIENT INFORMATION

Name (last, first, middle):	Date of Birth (mm/dd/yyyy):	Gender (M/F):
Email Address:	Home Phone Number:	Cell Phone Number:
Address:	City:	State & Zip Code:
Do you have active health insurance? (Y/N)	Household Size:	Household Income (pre-tax):
Boston Heart Accession Number (if known):	Ordering Physician:	Client ID:

STEP 2: SELECT ASSISTANCE TYPE - PICK ONE OPTION

Option 1: Patient does not carry insurance

Option2: Patient does carry insurance*

Out-of-pocket costs are discounted on a sliding scale based on household size and pre-tax income is under the amount listed in the table below.

Household Size	100% Discount	90% Discount	80% Discount	70% Discount	60% Discount	40% Discount
1	\$14,580	\$21,870	\$29,160	\$36,450	\$43,740	\$58,320
2	\$19,720	\$29,580	\$39,440	\$49,300	\$59,160	\$78,880
3	\$24,860	\$37,290	\$49,720	\$62,150	\$74,580	\$99,440
4	\$30,000	\$45,000	\$60,000	\$75,000	\$90,000	\$120,000
5	\$35,140	\$52,710	\$70,280	\$87,850	\$105,420	\$140,560
6	\$40,280	\$60,420	\$80,560	\$100,700	\$120,840	\$161,120
7	\$45,420	\$68,130	\$90,840	\$113,550	\$136,260	\$181,680
8	\$50,560	\$75,840	\$101,120	\$126,400	\$151,680	\$202,240

Income values are pre-tax and based on 2024 poverty guidelines (<https://aspe.hhs.gov/poverty-guidelines>). Boston Heart uses two times the federal poverty guidelines. Some insurance carriers choose to use the federal poverty guidelines. This may disqualify some applicants for assistance.

Extenuating circumstances considered – check if applicable and provide supporting documentation:

Unemployed Deceased Spouse

*Please complete the insurance information section below and include a copy of the patient's insurance card, front and back, along with this application. Patients covered by contracted insurance carriers may not be eligible for financial assistance.

Insurance Carrier: _____ Insured: _____

Policy/Member ID: _____ Group: _____

STEP 3: PATIENT ATTESTATION

I hereby acknowledge that the above information is true. I understand that I am responsible for supplying Boston Heart with the required proof of income to verify the information provided on this form for the purposes of assessing financial need. I understand that if I do not qualify, I will be notified and Boston Heart will bill me for the services rendered.

→ Patient Signature:	Date:
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STEP 4: PATIENT MUST PROVIDE INCOME DOCUMENTATION

Boston Heart must receive confirmation of patient's household income before providing patient assistance, including: wages, social security, pension/retirement, dividends/interest, rents/royalties, unemployment or worker's compensation, alimony, or other assets. **Please provide the patient's most recent form 1040 (from the patient's federal tax return) or Social Security (SSI) benefits.**

Fax completed application and all supporting documents to Boston Heart Billing Customer Care at 866.324.3929 or forward via email to Pass@Bostoheartdx.com

For Internal Use Only

Reviewed by:	Amount Due:	% Approved:	Adjusted Amount:	Denial Reason:
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