Athena Alliance Program Patient Financial Assistance Application

Patient Name _____ Telephone number _____

Address _____ Date of birth _____

City _____ State _____ Zip code _____

Does the patient have medical insurance coverage? ☐ Yes ☐ No

If "Yes," please list responsible party information (If possible, include a copy of insurance card)

Insurance company name _____ Policyholder name _____

Insurance company address _____ Policyholder ID number _____

Insurance company phone number _____

Current total annual gross household income $ _____

Total household income includes the following for all household members: gross salary, unemployment compensation, disability, worker's compensation, Social Security and/or supplemental (SSI) benefits, public assistance (TANF, SNAP, etc.), and other income.

Number of family members in household supported by the above income _____

Total household income is the tax filer, their spouse if they have one, and their tax dependents.

Optional: Please advise of any special circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

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I hereby acknowledge that the above information is true and correct. I authorize Athena Diagnostics to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request. I understand that if I do not qualify, I will be notified and Athena Diagnostics will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Responsible party (print) _____ **Date** _____

Responsible signature _____

For official use only

Bill number	Amount $	Approved	Denied
Date received			
Supervisor signature			

Athena's financial assistance program can help you if you are in 1 of these 2 groups:

- Patients who have incomes that are not more than 400% of the current HHS Poverty Guidelines (income guidelines) will pay no more than $100. If the patient responsibility indicates an amount less than $100, the patient is responsible for the lesser amount.
- Patients who have incomes that are between 400% and 600% of the income guidelines will pay no more than $400.

Note: Financial assistance does not apply if your insurance provider decides that you owe less than $100. Athena's financial assistance program will not reduce the amount you owe if it is already less than $100.

Patients who *do not qualify* for Athena's financial assistance program are in any of these 4 groups:

- Patients who have incomes that are > 600% (more than 6 times) the federally established income guidelines
- Patients who owe less than $100
- Patients who do not complete, sign, and return the financial assistance application
- Patients who do not provide an Explanation of Benefits (EOB) and/or payment when these are received directly from their insurance provider

Income eligibility chart*		
Family size	**Up to 400% (up to 4 times)**	**Up to 600% (up to 6 times)**
1	$58,320	$87,480
2	$78,880	$118,320
3	$99,440	$149,160
4	$120,000	$180,000
5	$140,560	$210,840
6	$161,120	$241,680
7	$181,680	$272,520
8	$202,240	$303,360
Each additional member	+$20,560	+$30,840
Maximum financial responsibility	Patient responsibility up to $100	Patient responsibility up to $400

* Adapted from https://aspe.hhs.gov/poverty-guidelines. Accessed on January 21,2023