

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.

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	\$51,520	\$77,280
2	\$69,680	\$104,520
3	\$87,840	\$131,760
4	\$106,000	\$159,000
5	\$124,160	\$186,240
6	\$142,320	\$213,480
7	\$160,480	\$240,720
8	\$178,640	\$267,960
Each additional member	+\$18,160	+\$27,240
Maximum financial responsibility	Patient responsibility up to \$100	Patient responsibility up to \$400

* Adapted from <https://aspe.hhs.gov/poverty-guidelines> accessed on 2/9/2021