NPI: 1336325497

CLIA ID: 07D1036625
CT License: CL-0644
NY Permit: PFI 8648
RI License: LCO-00591
CA License: COS 00800405
FL License: 800026696

LABORATORY OF PERSONALIZED HEALTH
Division of Genomas Inc.
67 Jefferson Street · Hartford CT 06106
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FINANCIAL ASSISTANCE PROGRAM (FAP)

This document outlines the *Financial Assistance Program (FAP)* of the Laboratory of Personalized Health (LPH). The Program offers discounted pricing for services to patients who meet the LPH criteria for Financial Assistance.

Eligibility for Financial Assistance
Patients who are uninsured, underinsured (high deductible plans), ineligible for any government health care benefit program (Medicaid, Medicare, State Assistance Programs, etc.) and unable to pay for their LPH laboratory services, may be eligible for financial assistance under this Program. Patient must be a U.S. citizen or legal resident.

Process for Determining Eligibility for Financial Assistance
In determining eligibility for financial assistance, LPH will require the patient complete an application for Financial Assistance along with other financial information and documentation relevant to making a determination of financial eligibility.

Financial Assistance Guidelines
The program is available to patients in need of financial assistance based on their household *Adjusted Gross Income (AGI).* Before determination will be made, one of the following documents is required: (1) *Prior Year Tax Return* or (2) *Current Pay Stub(s).*

Household Adjusted Gross Income (AGI)	Discounted Cost of Services *Per Test*
$0 to $50,000	**$100.00**
$50,001 to $100,000	**$175.00**
$100,001 to $150,000	**$250.00**

Note: **The HILO*met* PhyzioType System requires 3 tests: *CYP2C9, CYP2C19, CYP2D6***

Method for Applying for Financial Assistance Program (FAP)
Patients with an amount due LPH after their insurance has been billed will be advised by mail of the amount due. Patients who cannot pay the amount due or are uninsured may request a FAP application by reaching the LPH Customer Service Specialist at Telephone 860-545-4574 or by accessing the form at the website *www.genomas.com/LPH*

Regulatory Compliance
LPH will comply with all state and federal laws, rules and regulations applicable to the conduct of this Program.

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APPLICATION FOR THE FINANCIAL ASSISTANCE PROGRAM (FAP)

Patient Name: ____

Patient Address: ____

City, State and Zip Code: ____

Home Telephone: ________________________ Mobile Telephone: ________________________

Household Adjusted Gross Income: $_____________ *(see Requirement for Proof of Income, below)*

Residency Status:
Are you a U.S. Citizen or Legal Resident?
Please check the applicable box.

YES	
NO	

Note: If you checked "No" above, you are NOT eligible to participate in the FAP.

REQUIRED CERTIFICATION AND SIGNATURE BY PATIENT

I certify that I do not participate in any State or federally funded assistance programs (Medicaid, Medicare, State Assistance Programs, etc), and that the above information is true and accurate. I further understand that available funds are used only after all other sources of third party payment have been exhausted.

Patient Signature: ____ Date: ___________________

Eligibility for Financial Assistance

Patients who are uninsured, underinsured (high deductible plans), ineligible for any government health care benefit program (Medicaid, Medicare, State Assistance Programs, etc) and unable to pay for their LPH testing services, may be eligible for financial assistance under this Program. Patient must be a U.S, citizen or legal resident.

Requirement for *Proof of Income*

Please include your most recent tax return with this application. Additional documentation may be requested following LPH review.

Return completed application to: **Customer Service Specialist**
Laboratory of Personalized Health
67 Jefferson Street
Hartford, CT 06106