Application for Financial Assistance

HalioDx is committed to provide financial assistance in helping patient cost. The application is used to determine if you are qualified for a reduced out of pocket responsibility. Please complete all of the requested information below, sign at the bottom and return the signed form and supporting documents to HalioDx at 737 North 5th St, Suite 600, Richmond, VA 23219, fax to (804) 533-1504 or email information to billing@haliodx.com.

☐ I am applying for Financial Assistance

Personal Information

Patient's Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Date of Service: _____

Number of Persons in the Household (includes self): _____

Total Household Income: _____

Out-of-pocket costs are discounted on a sliding scale. Please see attached Program Rules

☐ **I certify that I do not have medical coverage through any Federal, state or government plans**

Supporting documents attached:

☐ W2 ☐ Paystubs ☐ Income Tax Return

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Financial Assistance program requirements. I authorize HalioDx to use my financial information to determine my eligibility.

_____ Date: _____
Patient Signature