Clarity Lab Solutions Financial Assistance Program (Clarity Cares) Application

Please complete the information below for your healthcare provider-ordered test:

I certify that I do **not** carry any Federally-funded health insurance (i.e. Medicaid, Medicare, Medicare Advantage, TriCare).

Check one. I am applying for:

☐ **Uninsured Assistance –** I do not have any medical health insurance. If I meet the low income criteria, I understand that my out of pocket expense will be limited to a maximum of $125 based upon the test performed.

☐ **Under – insured Assistance** – I currently have medical insurance coverage with _____ and have supplied all current policy information to my clinician's office for submission with my Test Request Form. If I meet the low-income criteria for my healthcare provider – ordered test, I understand any out-of-pocket expense resulting from my medical insurance claim will be limited to a maximum of $125 based upon the test performed.

Household Annual Gross Income (AGI): $_____ Note: AGI includes the following for all members of your household: Gross salary, Unemployment Compensation, Disability and Worker's Compensations, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.) As supporting documentation, please submit a copy of the first page of you most recent tax return (IRS form 1040, 1040A, 1040EZ). If you are unable to submit a tax return, briefly describe in the space below your income source(s) and why your tax return is not available.

- **Number of family members in household supported by above income:_____**

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Clarity Lab Solutions Financial Assistance Program ("Program") requirements, and understand the Clarity Lab Solutions, LLC. Reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to audit the information I have provided on this application.

_____

Patient Signature *Date*

_____

Printed Name *Date of Birth*

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