Hardship Assistance Program

Genesis Reference Laboratories is the Clinical Laboratory chosen to perform qualitative and quantitative toxicology, gastrointestinal, or respiratory testing by your treatment program, and/or physician. Genesis Reference Laboratories has established a Hardship Assistance Program to ensure you get the laboratory testing you need, without the additional burden of the cost. To be considered for the Hardship Assistance Program, you must complete this application and provide all the necessary documentation associated with proof of income to our facility. If approved, this application will automatically expire after 12 months from the date the application is approved. If there is no change in the patient's financial status, an annual renewal of the hardship assistance program is required.

A patient can qualify for hardship based on the following circumstance(s):

1. Genesis Reference Laboratories must have received a valid order for lab testing services from your treating healthcare provider.
2. The patient has no health insurance.
3. The patient has health insurance, but the payor does not cover services performed by Genesis Reference Laboratories.
4. The patient is unable to pay the charge for services due to a hardship.

To apply for the Hardship Assistance Program, you must complete:

1. The patient authorization along with the employment and household disclosure form (Pg. 2 - 3)
2. Provide documented proof of income. Please provide two of the following:
    a. W- 2 withholding statement
    b. Two most recent paycheck stubs
    c. Most recent income tax return
    d. Medicaid/Medicare eligibility or other state-funded medical assistance programs
    e. Welfare status documentation

Once your completed application has been received. Please allow approximately two business weeks for your application to be reviewed and processed. We recommend to not make any payments until you receive notification regarding the status of your application.

Please note: The program will be regularly assessed to ensure utilization is appropriate and aligned with the intended patient population. Genesis Reference Laboratories reserves the right to deny eligibility and discontinue the program in the absence of compliance by patients or our business partners.

ALL INFORMATION PERTAINING TO FINANCIAL HARDSHIP REQUESTS WILL BE KEPT CONFIDENTIAL AT THE HEADQUARTERS OF GENESIS REFERENCE LABORATORIES

Patient Authorization

If approved, the patient agrees to the following requirements:

1. The patient consents to have Genesis Reference Laboratories store their application on file for a period of 12 months.
2. If the patient obtains insurance during the 12-month period that they are enrolled in the hardship program, it is their responsibility to notify Genesis Reference Laboratories and their physician's office immediately, in order to timely withdraw from the hardship program.
3. If the patient's financial status does not change within 12 months, they consent to an annual renewal of the hardship program for documentation and compliance purposes.

I, _____ , authorize Genesis Reference Laboratories to:
(Print only)

1. Run laboratory tests on my specimens as requested by my referring facility and/or physician. Release the results of the laboratory tests to the ordering physician and facility.
2. Release my specimen upon the physician's written request for confirmation.
3. Collect and use any medical information necessary to process my specimen.
4. If applicable, bill my insurance provider for the laboratory testing services.
5. Receive payments of benefits for laboratory testing performed.

I understand if my insurance provider pays me directly, then I am responsible for sending the countersigned check and full payment amount to Genesis Reference Laboratories within 10 business days of having received the payment from my insurance provider and statement from Genesis Reference Laboratories.

_____
(Initials)

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ (MM/DD/YYYY)

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Account Number: _____ (Listed on the left side of statement under patient name)

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Insurance Information:

_____ I do not have insurance Primary Insurance: _____ I have insurance (provide insurance details below)

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

GENESIS REFERENCE LABORATORIES

Verification Information

Employment and Household Information

Employment Status:

_____ Employed _____ Unemployed

_____ Retired _____ Disabled

Household Information:

Number of persons in household: _____

Household Annual Income: _____

Briefly explain why you would have trouble paying your laboratory bill(s):

_____

_____

_____

_____

Responsible Party/ Legal Guardian Information:

Name: _____ Relationship: _____ Phone: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip Code: _____

I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I authorize the release of any and all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified and Genesis Reference Laboratories will bill me and my insurance provider if applicable.

Patient Name *(Please Print)*: _____ Date: _____

Patient or Legal Guardian Signature: _____

Please submit this form to CET@genesisreferencelabs.com Allow two business weeks for all responses. For immediate assistance please contact the CET team at (844) 510-0194.

For office use only		
Specimen ID	**Status**	**Date**

2022 POVERTY GUIDELINES Persons in family/household

Persons in family/household	Poverty guideline
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630

For families/households with more than 8 persons, add $4,720 for each additional person.