InSourceDx
FOUNDED BY SCIENTISTS

Request for Medical Financial Assistance

PRACTICE INFORMATION

Patient's last name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth Date / /	Age	Sex ☐ M ☐ F	Best Time to Contact You	Best Contact Number ( )
Street Address		Social Security No.		Home Phone Number ( )
P.O. Box	City	State		ZIP Code

FINANCIAL INFORMATION

Current annual household gross income	$
Number of household members dependent on the income stated above (including the applicant)	
Number of yearly drug screens	
Number of dependents currently attending college	
Annual tuition costs for the dependents listed above (please provide documentation)	$
Monthly mortgage, rent or property tax payment (please provide documentation)	$
Monthly car payments (please provide documentation)	$
Annual medical expenses (please provide documentation)	$

APPLICATION DECLARATION

I attest that the information provided is complete and accurate.

I agree that at any time during my enrollment, InSource Diagnostics Corp. may request additional documents to authenticate the statements made on my application.

I understand that InSource Diagnostics Corp reserves the right to change or discontinue this program at any time.

Patient/Guardian Signature _____ Date _____

In order to verify eligibility, the following documents are required:

- ☐ Copy of your most recent tax return and/or the past 2 years W-2's for all wage earners
- ☐ Copy of any correspondence from your insurance company related to the reimbursement of the drug test
- ☐ Documentation verifying monthly expenses categorized above