6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

FINANCIAL ASSISTANCE APPLICATION FORM

Enrollment Application for the AxioBionics Charitable Mission Discount Program

AXIOBIONICS' CHARITABLE MISSION

Wearable Therapy® is not always covered by medical insurance. In keeping with our mission of helping as many patients as possible, AxioBionics will evaluate patients lacking in insurance coverage or the means to pay the cost of its products on a case by case basis and may, in accordance with its policy, elect to lower the cost to ensure that as many patients as possible have access to its technology to alleviate human suffering and improve quality of life.

Applicants for financial assistance will be expected to fully cooperate in applying for any public or private insurance programs that we believe you may be eligible for (e.g., Tricare, VA Health Benefits, Blue Cross Blue Shield, Aetna, and other forms of health insurance, etc.)

Upon receipt of your completed application and all required documents, your application will be reviewed and our determination will be sent to you in writing within 30 days. If you have any questions, feel free to contact us.

PATIENT (OR RESPONSIBLE GUARDIAN) MUST FILL OUT THIS FORM COMPLETELY

Name of Person Completing this Form ____________________ Name of Patient ____________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian

Street Address ____________________

City ____________________ State ____________________ Zip Code ____________________

Country: ☐ United States

Country ____________________

Email ____________________ Phone ____________________

PATIENT INFO

Are you a veteran? ☐ Yes ☐ No

Do you own or rent your home?

☐ Own ☐ Rent

HOUSEHOLD INFO

Total # of dependents in your household, including self:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

How many are living with a disability? ____________________

Do you have access to a Trust, or other funds, that cover Medical Expenses? ☐ Yes ☐ No

Do you have MI Auto Insurance or is your injury covered by Workers' Compensation? ☐ Yes ☐ No

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FINANCIAL INFO

Gross Monthly Income- list all sources:

Salary/Wages (All sources)	$	______________
Pension/Retirement	+ $	______________
Social Security	+ $	______________
Disability	+ $	______________
Workers Compensation	+ $	______________
Unemployment Benefits	+ $	______________
Alimony/Child Support	+ $	______________
Other: ______________	+ $	______________

(Explain sources: Dividends, Interests, Rental Income...)

Total Gross Monthly Household Income $ ______________

Monthly Household Expenses $ ______________

Extenuating Medical Expenses- over the last 5 years:
(For example: Equipment/Services or Medical Bills you personally paid)

Therapy	$	______________
Patient Care	+ $	______________
Medications	+ $	______________
Wheelchair/Equipment	+ $	______________
Other: ______________	+ $	______________
Other: ______________	+ $	______________
Other: ______________	+ $	______________

(Explain "Other" costs: Transportation costs, Wheelchair Van, Home Modifications, etc.)

Total Extenuating Expenses over the last 5 years $ ______________

I certify to the best of my knowledge that the information and documentation provided is truthful, complete and accurate. I understand that the information I submit is subject to verification and any willful misrepresentation of these facts will make me liable for all charges. I agree to work with AxioBionics to seek reimbursement from my medical insurance. I am aware that medical insurance does not always cover AxioBionics services. I understand that it is my responsibility to promptly advise AxioBionics of any changes to my income or assets.

______________ ______________ ______________
Print Name Signature Date