



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 our 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 _____

Relationship to Patient: Self Parent Guardian

Name of Patient _____

Patient Date of Birth: _____

Date of Onset of Condition: _____

Street Address _____

City _____

State _____

Zip Code _____

Country: United States

Other: _____

Country _____

Email _____

Phone _____

PATIENT INFO

Are you a veteran? Yes No

Do you own or rent your home?

Own Rent

FAMILY SIZE

Total # of family members 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

Will you be using CareCredit to pay?

Yes

No



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 \$ _____

Total ANNUAL Household Income (Total Gross Monthly x 12) \$ _____

Monthly Household Expenses \$ _____

Extenuating Medical Expenses incurred since injury or onset of condition, or in the last 5 years, whichever is less:

(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 \$ _____

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