NantHealth® | Liquid GPS™ | GPS Cancer®

Financial Assistance Application

NANTACCESS PROGRAM

FAX TO: 1.866.728.3945

To apply for financial assistance through the NantAccess Program, please complete the application below. The information you provide will be used solely to determine program eligibility. Please fax the completed application to 1.866.728.3945.

Program eligibility is based on various factors including insurance provider, household income, the number of people in the household, college tuition expenses, medical care costs, and other expenses. For any questions about the NantAccess Program, please contact us at 1.844.MY.OMICS, and you will be connected with a billing specialist.

Please print.

DATE	EMAIL ADDRESS*

* For rapid notification of application status and potential out-of-pocket rates via secure email, please provide your email address. Alternatively, we will contact you at the phone number provided.

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ SINGLE ☐ MAR.
☐ MS. ☐ MISS. ☐ DIV. ☐ SEP.

▲ LAST NAME | ▲ FIRST NAME | ▲ MIDDLE | TITLE | MARITAL STATUS

▲ BIRTH DATE | ▲ AGE | ▲ SEX | ▲ BEST TIME TO CONTACT YOU | ▲ BEST CONTACT #

▲ STREET ADDRESS | ▲ HOME PHONE #

▲ P.O. BOX # | ▲ CITY | ▲ STATE | ▲ ZIP CODE

FINANCIAL INFORMATION

To determine your eligibility for financial assistance, NantHealth compares your income, less eligible expenses, to federally established income guidelines. Expense information is not required, but providing more complete information may increase the likelihood of assistance. You may use the worksheet on page 2 of this form to calculate your total monthly expenses.

* Required Fields

*WHAT IS YOUR MONTHLY NET INCOME? *Include employment, retirement, social security, disability, or other income*	$
*NUMBER OF HOUSEHOLD MEMBERS DEPENDENT ON THE INCOME STATED ABOVE	#
WHAT ARE YOUR TOTAL MONTHLY EXPENSES? *Use worksheet on page 2 to calculate*	$

APPLICATION DECLARATION

I certify that the information provided on this form is true and correct. I authorize NantHealth and its affiliated entities to use and confirm this information for the purpose of determining my eligibility for financial assistance with respect to services prescribed for me by my treating physician. I understand that I am not guaranteed financial assistance and any assistance provided is determined in accordance with NantHealth protocols and based on an individual analysis of the information I provide. I further understand that NantHealth may change or discontinue this program at any time.

▲ PARENT | GUARDIAN SIGNATURE | ▲ DATE

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EXPENSE WORKSHEET (OPTIONAL)

You may use this worksheet to calculate your total monthly expenses. Please write the total in the space provided on page 1 of this form. It is not necessary to return this worksheet with your completed application.

MONTHLY TUITION COSTS FOR DEPENDENTS	$
MONTHLY MORTGAGE OR RENT PAYMENT	$
MONTHLY / ANNUAL PROPERTY TAXES AND HOME INSURANCE	$
MONTHLY UTILITIES	$
MONTHLY CAR PAYMENT(S) AND INSURANCE	$
OTHER MONTHLY TRANSPORTATION EXPENSES	$
MONTHLY MEDICAL BILLS / EXPENSES	$
MONTHLY FOOD EXPENSES	$
OTHER MONTHLY EXPENSES *e.g. credit card payments, alimony payments*	$
TOTAL MONTHLY EXPENSES *Add all lines above and write total in the space provided on page 1*	$