financial assistance program application

The Allergenis Financial Assistance Program is available to help eligible patients reduce their costs for the Allergenis Peanut Diagnostic. Qualification is based on your household income, the number of people in the household, and other federal guidelines.

Patient Information	
Last Name:	First Name:
DOB: (MM/DD/YYYY)	Sex: Female ☐ Male ☐
Street Address:	City: State: Zip:
Phone:	Email:
☐ I authorize Allergenis to leave a detailed voicemail at this number.	☐ I attest I **do not** have insurance and elect to pay for the Allergenis Peanut Diagnostic by check or credit card.
Caregiver Information:	
Last Name:	First Name:
Ordering Allergist	
Last Name:	First Name:

Adjusted Gross Income (AGI)	Number of Members in Household
$	
Extenuating Circumstances	
Describe Extenuating Circumstance:	

Signature	
Patient Name or Guardian (Print)	Signature (Required)
Relationship to Patient:	Date:

Included with this application, please provide the following types of proof include wage verification (the first two (2) pages of his/her most recent tax return (Form 1040), unemployment information, Social Security award letters, self-employment records, disability or worker's compensation, alimony, child support, pensions, etc. If you have questions, please contact us at 888-436-6339.
Once processed, we will send a statement with the amount due based on Federal Poverty Levels. Allergenis is committed to providing laboratory services that are affordable and reliable. We appreciate your trust and will work with you to make our services affordable for all patients.

Please remit the application and attached document to the address below:

Allergenis, LLC
PO BOX 784226
Philadelphia, PA 19178-4226