ARBORETUM CLINICAL

Genetic Testing Financial Assistance Application

Arboretum Clinical, LLC

Return by email billing@arboretumclinical.com | Fax 617-465-0695 | Questions? Call (617) 798-2477
Mail to Arboretum Clinical, 245 Main St Fl 2, Cambridge MA 02142

This is not an order for a test. The patient, a representative, or the ordering practice may complete it.

*** = Required**

1. PATIENT INFORMATION

***Last name** | ***First name** | **MI** | ***Date of birth (MM/DD/YYYY)**

***Street address** | **Apt #** | ***Sex** ☐ Female ☐ Male

***City** | ***State** | ***ZIP** | **Account # (if known)**

***Phone** | ***Email** | ***Send the decision to** ☐ Patient ☐ Practice

2. TEST ORDERED AND ORDERING PROVIDER

***Test ordered (check all that apply)**

- ☐ Arboretum Familial Hypercholesterolemia Test
- ☐ Arboretum Coronary Artery Disease PRS Test
- ☐ Arboretum Hereditary Cardiomyopathy Test
- ☐ Arboretum Hereditary Arrhythmia Test
- ☐ Arboretum Combined Hereditary Cardiomyopathy and Arrhythmia Test
- ☐ Arboretum Hereditary Aortopathy Test
- ☐ Arboretum Hereditary Cancer Test
- ☐ Other:

***Practice or facility name**

***Ordering physician** | ***Phone** | **Fax**

3. HOUSEHOLD INCOME

***Annual gross household income ($)** | ***Number of people in household**

For reference: 2026 financial assistance scale

If approved, the most you would owe	$0	$50	$100	$150	$200	$250 cash pay only
Household size	**at or below 225% FPL**	**225 to 350% FPL**	**350 to 450% FPL**	**450 to 550% FPL**	**550 to 650% FPL**	**above 650% FPL**
1	$35,910	$55,860	$71,820	$87,780	$103,740	over $103,740
2	$48,690	$75,740	$97,380	$119,020	$140,660	over $140,660
3	$61,470	$95,620	$122,940	$150,260	$177,580	over $177,580
4	$74,250	$115,500	$148,500	$181,500	$214,500	over $214,500
5	$87,030	$135,380	$174,060	$212,740	$251,420	over $251,420
6	$99,810	$155,260	$199,620	$243,980	$288,340	over $288,340
7	$112,590	$175,140	$225,180	$275,220	$325,260	over $325,260
8	$125,370	$195,020	$250,740	$306,460	$362,180	over $362,180

Figures are annual gross household income at the top of each band. Amounts are the cash-pay price if you have no insurance, or the most you would owe after insurance is billed.

Note: Above 650% FPL the $250 applies to cash pay only; a patient with insurance may qualify for a discount through Section 4.

Source: 2026 HHS Poverty Guidelines, 48 contiguous states and D.C. Add $12,780 per person above household size 8.

4. FINANCIAL HARDSHIP

Check anything below that applies to your household, then describe it briefly. Attach documentation in Section 5.

- ☐ Major life or housing event in the past 12 months, such as a move, the loss of a family member, or a change in caregiving
- ☐ Loss of income in the past 12 months, or unpredictable income from shift or gig work
- ☐ Dependent care costs above 10% of gross household income in the past 12 months
- ☐ Medical costs above 5% of gross household income in the past 12 months
- ☐ Other circumstance affecting your ability to pay

Briefly describe what you checked and how it affects your ability to pay

5. DOCUMENTS YOU ARE ATTACHING

Attach one proof of income or program enrollment. If you checked a hardship above, also attach documentation of it. A provider attestation of financial hardship may be sent in place of income documentation.

- ☐ First page of federal tax return
- ☐ Recent pay stub
- ☐ Proof of program enrollment
- ☐ Eviction or utility shut-off notice
- ☐ Recent bank statements
- ☐ Provider attestation of hardship
- ☐ W-2 from current or most recent employer
- ☐ Benefits award or denial letter
- ☐ Termination, layoff or reduced-hours notice
- ☐ Proof of medical expenses
- ☐ Proof of dependent care costs
- ☐ Other

6. SIGNATURE

I certify that the information in this application is true and complete to the best of my knowledge. I understand that Arboretum Clinical makes an individual determination of financial need, may request additional documentation, and may verify what I have provided. Assistance is not guaranteed and is based on the review of this application.

Signature of patient or personal representative

Printed name

Date

Relationship to patient, if not self

Office use only ☐ Charity care ☐ Provider attestation ☐ Other: Initials: