FINANCIAL ASSISTANCE APPLICATION

Ethos Laboratories is committed to providing financial assistance to patients who have healthcare needs and are uninsured, underinsured, ineligible for government programs and otherwise unable to pay for medical care based on their financial situation***. In order for your application to be processed, you must complete application and submit supporting documentation such as latest paystub, most recent W-2, unemployment letter or SSI benefits info to verify income***.

Patient Name_________________________________ Date of Birth_____________ Date of Service_________________

Address____

City______________________________ State____________________ Zip____________________

Phone______________________________ Email ____

Current Employer ___________________________ # of Hrs Per Week Worked: ______________________

Current Gross Annual Income of **Patient (attach documentation)** $ ______________________

Current Gross Annual Income of **Spouse (attach documentation)** $_______________________

Current Gross Annual Income of **Other Household Members** $_______________________

INCOME TOTAL: $_______________________

Number of dependents in household including Patient _____________________________________

Type of assistance requested:

☐ Financial Assistance ☐ Payment Plan

If you reported total income of $0.00 above, please have the Support Statement below completed by the person(s) helping to support you and/or your family or can verify that you have no income in your household.

SUPPORT STATEMENT

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being financially supported. List services, if any, that you are receiving from patient for providing support.

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I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge. I understand that my does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

____ _______________________________________

Signature of Person Providing Financial Support to Applicant Address of Person Providing Financial Support

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee a financial assistance discount or payment plan.

Patient Signature____**Date**_____________________

29 East 6th Street | Newport, KY 41071 | phone: 844-836-9137 | fax: 1-877-349-0243