

NeXT Access

Financial Assistance Program Application



PATIENT INFORMATION

First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	Account #
Address			City	State
Phone			Email Address	

FINANCIAL INFORMATION

Household Size (including patient)	Total Household Income (annual gross)
Total household income shall include all sources of income including social security, public assistance, unemployment, worker's compensation, veteran's benefits, child support, alimony, wages, bonuses, and/or etc.	

PATIENT ATTESTATION

I hereby certify that the information provided on this form to Personalis is true and accurate to the best of my knowledge. I understand and agree that Personalis reserves the right, at any time and without notice, to modify the application or terminate this program. I also certify that I do not carry any U.S. federal or state-funded health insurance (i.e., Medicare, Medicaid, Tricare, Medicare Advantage).

Patient/Guardian Signature	Printed Name	Date (MM/DD/YYYY)
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The information provided on this form will be kept confidential. The information is for internal purposes only and will only be used to determine eligibility for the financial assistance program and will not be disclosed to any third parties without prior written consent.