6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

FINANCIAL ASSISTANCE APPLICATION FORM

Enrollment Application for the AxioBionics Charitable Mission Discount Program

AXIOBIONICS' CHARITABLE MISSION

Wearable Therapy® is not always covered by medical insurance. In keeping with our mission of helping as many patients as possible, AxioBionics will evaluate patients lacking in insurance coverage or the means to pay the cost of its products on a case by case basis and may, in accordance with its policy, elect to lower the cost to ensure that as many patients as possible have access to our technology to alleviate human suffering and improve quality of life.

Applicants for financial assistance will be expected to fully cooperate in applying for any public or private insurance programs that we believe you may be eligible for (e.g., Tricare, VA Health Benefits, Blue Cross Blue Shield, Aetna, and other forms of health insurance, etc.)

Upon receipt of your completed application and all required documents, your application will be reviewed and our determination will be sent to you in writing within 30 days. If you have any questions, feel free to contact us.

Patient (or responsible guardian) must fill out this form completely.

Name of person completing this form

Name of Patient

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian

Patient Date of Birth: _____

Date of Onset of Condition: _____

Street Address Line 1

Patient's Diagnosis

Street Address Line 2

Phone

City

Email

State

Zip Code

Country:

☐ U.S. Other Country

Total # of family members in your household, ***including self***:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

How many are living with a disability? _____

Do you have access to a trust, grant, or other funds, that cover Medical Expenses? ☐ Yes ☐ No

If Yes, how much is your trust, grant or other funding?

☐ < $5,000 ☐ $5,000 - $10,000 ☐ $10,000 - $25,000 ☐ $25,000 - $50,000

☐ < $50,000 - $100,000 ☐ $100,000 – $500,000 ☐ $500,000 +

Do you have MI Auto Insurance or is your injury covered by Workers' Compensation? ☐ Yes ☐ No

Will you be using CareCredit to pay? ☐ Yes ☐ No

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FINANCIAL INFORMATION

Monthly **Income**- list all sources:

Salary/Wages *after* taxes (combined from all sources)		$
Pension/Retirement	+	$
Social Security	+	$
Disability	+	$
Workers Compensation	+	$
Unemployment Benefits	+	$
Alimony/Child Support	+	$
Other: _____	+	$

(Explain "Other" sources: dividends, interests, rental income...)

Total *Monthly* Household Income $

Total ANNUAL Household Income (Total Monthly Income x 12) $

Monthly **Household Expenses** (estimate bills incl. mortgage/rent, utilities, etc.) $

ANNUAL Household Expenses (Monthly Expenses x 12) $

Extenuating Medical Expenses (relating to the care of one or more disabled family members) incurred since injury or onset of condition, or in the last 5 years, *whichever is less*. Include only expenses not typically covered by insurance. (For example: equipment, services, or medical bills you personally paid)

Therapy		$
Patient Care	+	$
Medications	+	$
Wheelchair/Equipment	+	$
Other: _____	+	$
Other: _____	+	$
Other: _____	+	$

(Explain "Other" costs: transportation costs, wheelchair van, home modifications, etc.)

Total Extenuating Expenses $

I certify to the best of my knowledge that the information and documentation provided is truthful, complete and accurate. I understand that the information I submit is subject to verification and any willful misrepresentation of these facts will make me liable for all charges. I agree to work with AxioBionics to seek reimbursement from my medical insurance. I am aware that medical insurance does not alway cover AxioBionics services. I understand that it is my responsibility to promptly advise Axiobionics of any changes to my income or assets.

Print Name _____ Signature _____ Date _____