DRUGSCAN INC., an ACM GLOBAL LABORATORY
FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient's Name _____ _____ _____ _____
First Last MI Date of Birth

Responsible Party _____ _____ _____
First Last MI

Address _____ _____ _____ _____
Street City State Zip Code

Phone_____ Household Size _____

Household Information

Please list everyone who lives with you, even if they are not applying for assistance.
Place a √ checkmark before each name below to indicate who is applying for Financial Assistance.

Applying for Financial Assistance	Name	Date of Birth	Relationship to Patient
☐			
☐			
☐			
☐			
☐			
☐			

□

Medicaid / Other Insurance Statement

1. I/We ☐ **have** ☐ **have not** applied for Medicaid, Child Health Plus, or other health insurance to cover these services.

   If not, please explain reason: _____.

2. Please explain reason for financial hardship: _____

   _____

******PLEASE TURN OVER / COMPLETE PAGE TWO (2) OF THE APPLICATION****** *DO NOT COPY IN PATIENT'S CHART*

Mail application to: DrugScan Inc,, Attn: Billing Customer Service, 200 Precision Road Suite 200, Horsham PA 19044
Email: patientbilling@drugscan.com **Fax:** 888-972-1105

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Types of Income

Wages and Salary
- Paycheck Stubs
- Letter from employer on company letterhead, signed and dated
- Current signed and dated income tax return and all Schedules
- Business/payroll records

Self-Employment
- Current signed and dated income tax return and all Schedules
- Records of earnings and expenses/business records

Unemployment Benefits
- Award letter / certificate
- Monthly benefit statement from NYS Department ofLabor
- Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us)
- Copy of Direct Payment Card withprintout
- Correspondence from the NYS Department ofLabor

Social Security (Retirement / Disability)
- Award letter / certificate
- Annual benefit statement
- Correspondence from Social SecurityAdministration

Worker's Compensation
- Award letter
- Check stub

Child Support / Alimony
- Letter from person providingsupport
- Letter from court
- Child support/alimony check stub
- Copy of NY Epicard withprintout
- Copy of child support account informationfrom www.newyorkchildsupport.com
- Copy of bank statement showing directdeposit

Military Pay
- Award letter
- Check stub

Income from Rent or Room/Board
- Letter from roomer, boarder, tenant
- Check stub

Interest/Dividends/Royalties
- Recent statement from bank, credit union or financial institution
- Letter from broker
- Letter from agent
- 1099 or tax return (if no other documentation is available)

Private Pensions/Annuities
- Statement from pension / annuity

Veteran's Benefits
- Award letter
- Benefit check stub
- Correspondence from VeteransAffairs

Household Income

Proof of household income is required. Please write in the amount and type of monies received by all members of the Household listed on Page 1 and attach proof of income with the completed application.

Name of Person	**Type of Income** (see above)	**Gross Income Amount** (Before Taxes)	**Received how often?** (Weekly, Monthly, etc.)

I certify the above information is true and accurate to the best of my knowledge. Furthermore, I will apply for any assistance (Medicaid, Medicare, Commercial Insurance, etc.) which may be available for payment of my hospital charges. I will take any action reasonable necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand Rochester Regional health may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of Patient or Responsible Party: X _____ Date: X _____

Please allow 30 days for application to be processed.

Once a patient has submitted a completed application for a Financial Assistance Discount, the patient may disregard any bill from Drugscan Inc. that might be sent until such time as DrugScan Inc. has rendered a determination on the pending application.