



FINANCIAL ASSISTANCE PROGRAM & APPLICATION

Baylor Genetics recognizes that genetic testing may create financial challenges. To support patients, Baylor Genetics offers a Financial Assistance Program (FAP) to help meet genetic testing needs.

To determine eligibility, the patient or legal representative should complete the information below and submit the form to billing@baylorgenetics.com.

The application may also be submitted via secure web form at: www.baylorgenetics.com/assistance-form/.

PROGRAM PROCESS & REQUIREMENTS

- FAP is available to apply for at any time throughout the process (e.g., prior to the test being ordered, while testing is being performed, or at the very end of the billing process after a statement has been issued).
- You must be a US resident to qualify for financial assistance.
- Financial assistance is for testing that is billed through insurance or for uninsured patients.
 - For patients with health insurance, the insurance provider will be billed first. The patient's qualified amount for financial assistance will be applied to any unpaid balance remaining after billing insurance. Financial assistance is not available for patients who have health insurance but are choosing to pay for testing themselves.
- To determine whether you qualify for Baylor Genetics' FAP, complete the form and submit the required information:
 - The patient / applicant's total annual gross household income (pre-tax).
 - This includes gross salary (e.g., wages), unemployment compensation, disability and worker's compensation, social security and/or supplemental (SSI) benefits, public assistance (e.g., TANF, SNAP, etc.), pension/retirement, dividends/interest, rents/royalties, alimony, child support, and/or other assets.
 - Household size (e.g., number in household).
 - This means individuals in the household supported by gross annual household income, including the patient.
- A member of Baylor Genetics' Billing team will reach out to the patient / applicant to discuss payment options, if the out-of-pocket cost is more than \$250.
- If the patient / applicant qualifies, financial approval will last for one calendar year. Any testing performed within that year will be covered by financial assistance.

PATIENT INFORMATION

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____

Applicant First Name (if different than the Patient) _____ Applicant Last Name (if different than the Patient) _____ Relationship to Patient _____ Email _____ Phone _____

Address _____ City _____ State _____ Zip _____

Are you a self-pay patient? ☐ Yes ☐ No Do you have health insurance? ☐ Yes ☐ No If yes, is your insurance through a State Medicaid Program? ☐ Yes ☐ No

Total Annual Gross Household Income _____ Number in Household _____

EXTENUATING CIRCUMSTANCES

Please check off any extenuating circumstances you would like us to consider:

- ☐ Significant medical expenses, including non-local travel expenses for treatment (e.g. hotel, airfare, etc.) >\$1,000.
- ☐ Alimony and/or child support expenses >\$1,000 per month.
- ☐ Financially supporting family member(s) outside of my household.
- ☐ Currently enrolled in short- or long-term disability with my employer.
- ☐ Temporary or permanent loss of income due to diagnosis or treatment.
- ☐ Other (write in or include when submitting the form):

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This table is based on the 2026 federal poverty guidelines and will be updated as federal guidelines change annually.

What You May Owe Based on Your Household Income

Household Size	You may owe \$0 if your income is at or below	You may owe \$150 if your income is at or below	You may owe \$250 if your income is at or below
1	\$31,920	\$63,840	\$95,760
2	\$43,280	\$86,560	\$129,840
3	\$54,640	\$109,280	\$163,920
4	\$66,000	\$132,000	\$198,000
5	\$77,360	\$154,720	\$232,080
6	\$88,720	\$177,440	\$266,160
7	\$100,080	\$200,160	\$300,240
8+	\$111,440	\$222,880	\$334,320

ATTESTATION

I understand and acknowledge that:

1. Baylor Genetics determines eligibility for financial assistance independently of the healthcare provider who is ordering the test.
2. Baylor Genetics may request additional information or documentation to verify information provided on this application.
3. I understand that approval is not guaranteed and that Baylor Genetics will notify me of the determination.
4. I further certify and agree that I will not seek reimbursement or credit for this testing from any insurer, or other source of financial assistance.
5. By signing below, I acknowledge that the information provided is true and complete.

Patient Representative Certification: If I am signing this application for the patient, I confirm that I have reviewed the purpose of this form with the patient and that the patient gave permission for me to complete it on their behalf. I also confirm that the details included in this application were provided by the patient and, to the best of the patient's knowledge, are true and complete. Signing this form does not make me financially responsible for the testing or related services. If I am the ordering physician, my signature also confirms that the patient was not able to sign this application at the time it was completed, and that no authorized representative was available or willing to sign for the patient.

This form is available online at www.baylorgenetics.com/assistance/. A Spanish version of the form is also available online.

Name of Patient or Authorized Patient Representative

Relationship to Patient
(Note: Not a required field)

Signature of Patient or Patient Representative

____ / ____ / ____
Date Signed (MM / DD / YYYY)

FOR INTERNAL (BAYLOR GENETICS) USE ONLY

- ☐ APPROVED
☐ DENIED

Approver's Name

Approved Amount

____ / ____ / ____
Date (MM / DD / YYYY)

