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Myriad Financial Assistance Program (MFAP) Application

Please complete the information below for your healthcare provider-ordered test:

I certify that I do not carry any Federally-funded health insurance (i.e., Medicare, Medicaid, Tricare, Medicare Advantage). Note: Patients with some types of Medicaid plans, including patients with limited state-funded plans, e.g. emergency only coverage, or Medicaid in states that do not have coverage for Myriad testing, are eligible for MFAP; contact Myriad for details about your specific plan type.

I am applying for: (select one)

- ☐ **Uninsured assistance**- I do not have any medical health insurance. If I meet both medical criteria and low-income criteria, I understand that my cost for testing will be limited to: $0 if my income is up to 2x federal poverty level (FPL); $100 if my income is 2-3x FPL; or $249 if my income is 3-4x FPL.
- ☐ **Underinsured assistance-** I currently have medical insurance coverage with _____ and have supplied all current policy information to my clinician's office for submission with my Test Request Form. If I meet both medical criteria and low-income criteria for my healthcare provider-ordered test, I understand any out-of-pocket expense resulting from my medical insurance claim will be limited to the amount listed above under Uninsured Assistance.

Number of family members in household supported by the income listed below: _____

Household Annual Gross Income (AGI): $_____ (Note: AGI includes the following for all members of your household: Gross Salary, Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.). As supporting documentation, please submit a copy of the first page of your most recent tax return (IRS Form 1040, 1040A or 1040EZ), or document summarizing income such as a W2. If you are unable to submit income documentation, briefly describe in the space below your income source(s) and why your tax return is not available:

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Myriad Financial Assistance Program ("Program") requirements, and understand that Myriad Genetic Laboratories, Inc. reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to audit the information I have provided on this application.

Patient signature	Date	Printed name	Date of birth