EXACT SCIENCES

5505 Endeavor Lane

PATIENT FINANCIAL ASSISTANCE APPLICATION

Patients applying for assistance must document their financial need. If the patient is a minor or otherwise unable to complete this form, a parent or legal guardian may do so.

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

Patient's Mailing Address: _____

Telephone: (_____)_____

Preferred Language: (circle one) SPANISH - ENGLISH

SECTION 1

Please provide **ONE** of the documents listed below:

a. A copy of last year's W2 form.

b. A copy of last year's Federal or State tax return (just the page(s) showing gross (pre-tax) income).

c. A copy of your latest Social Security check.

d. If currently unemployed, a copy of unemployment earnings.

e. Proof that you qualify for county, state, or federal assistance programs based on your income (e.g., Medicaid, Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Home Energy Assistance Program, etc.). **If you are unsure of what programs might qualify, please contact our Customer Care Center at 1-866-662-6897, Option 2**.

f. If you do **not** have any of the above documents, please describe your financial need and you may still qualify.

SECTION 2

Please estimate your annual gross (pre-tax) income for your entire household: $ _____
Number of people living in your household: _____

SECTION 3

I certify that all information provided to Exact Sciences is true and complete. I understand that Exact Sciences reserves the right to verify all information submitted and I acknowledge that my application **does not** guarantee that I will receive financial assistance of any kind.

Signature of Patient or Parent/Guardian: _____ Date: _____