# The ExoDx™ Prostate Test

## Patient Assistance Program

**The cost of The ExoDx Prostate may be reduced for patients who qualify for our Patient Assistance Program (PAP).** To be eligible, patients must meet the following criteria:

- Live in the United States or a U.S. Territory
- Have insufficient insurance coverage to pay for the test
- Meet income guidelines as detailed in the table below
- Complete the PAP application on the reverse side of this page

Patients should expect to be notified of their status within two weeks of submitting the completed application form. If the application is approved, patients may elect to pay the full amount or opt to set up an interest-free payment plan for up to 6 months. To apply, please complete the PAP Application on the reverse side of this page and submit via FAX to **617-649-4308** or mail to Exosome Diagnostics, 266 Second Ave., Suite 200, Waltham, MA 02451.

***We're here to help.*** If you have extenuating circumstances, please give us a call at **844-EXOSOME** (**844-396-7663**).

### Household income eligibility guidelines for the Patient Assistance Program*

| Household size | Income level 1 | Income level 2 | Income level 3 | Income level 4 | Income level 5 | Income level 6 | Income level 7 | Income level 8 |
|---|---|---|---|---|---|---|---|---|
| 1 | $12,760 | $25,520 | $38,280 | $51,040 | $63,800 | $76,560 | $89,320 | $102,080 |
| 2 | $17,240 | $34,480 | $51,720 | $68,960 | $86,200 | $103,440 | $120,680 | $137,920 |
| 3 | $21,720 | $43,440 | $65,160 | $86,880 | $108,600 | $130,320 | $152,040 | $173,760 |
| 4 | $26,200 | $52,400 | $78,600 | $104,800 | $131,000 | $157,200 | $183,400 | $209,600 |
| **Out-of-pocket cost** | **$50** | **$75** | **$100** | **$125** | **$150** | **$200** | **$250** | **$300** |

If you live in Alaska or Hawaii or have a household greater than 4 members, please call **844-396-7663**, **Option 3**.

**If you do not qualify for the PAP Program, we offer an interest-free payment plan. Please call 844-EXOSOME, Option 3, to learn more.**

*2020 poverty guidelines are in effect as of January 17, 2020. ExosomeDx follows poverty guidelines as set by the U.S. Department of Health and Human Services. Current guidelines can be found at **aspe.hhs.gov/poverty-guidelines**. Income levels are subject to change at any given time. Higher income levels not represented in this chart are associated with proportional out-of-pocket costs per our billing policy.

### Income verification

To apply, patients submit a completed PAP application form and provide at least one supporting document in the form of pages 1 and 2 of your previous year's tax return (form 1040 or 1040EZ), wage and tax statements (W-2 or 1099), two recent paycheck stubs, social security, pension or railroad retirement statements (SSA-1099 or similar), statements of interest, or other income (1099-INT, 1099, 1099-DIV or similar forms).

Exosome Diagnostics, Inc.
266 Second Ave., Suite 200
Waltham, MA 02451
(844) EXOSOME | (844) 396-7663
**exosomedx.com**

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# Patient Assistance Program application

## PATIENT INFORMATION

Last name

First name

Date of birth (MM/DD/YYYY)

Street address | Apt.

City | State | ZIP

Phone

Email

## ORDERING PHYSICIAN

Office / Practice / Facility name

Ordering physician

Date of test

City | State | ZIP

Phone

Email

## INCOME INFORMATION

Annual household income

Number of persons in household (including applicant)

## HOUSEHOLD INCOME VERIFICATION

***One or more verification methods is REQUIRED.***

- ☐ Page 1 and 2 of prior year tax return (form 1040 or 1040EZ)
- ☐ Wage and tax statements (W-2 or 1099)
- ☐ Two recent paycheck stubs
- ☐ Social security, pension or railroad retirement statements (SSA-1099 or similar)
- ☐ Two recent statements demonstrating disability or unemployment
- ☐ I have extenuating circumstances requiring individual verification

## PATIENT VERIFICATION

By signing below, I certify that I cannot afford the test and that my answers and proof of household income documents are complete, true and accurate to the best of my knowledge. I understand that completing the application does not guarantee that I will qualify for the Patient Assistance Program and that Exosome Diagnostics may verify the accuracy of the information I have provided and may ask for more income or insurance information. I also acknowledge that Exosome Diagnostics reserves the right to modify or cancel the program at any time.

Patient name or representative (pleae print)

Relationship to patient

Signature (required)

Date

## Return completed application with supporting documentation to:

**Fax:** 617-649-4308 | **Mail:** Exosome Diagnostics, Inc., 266 Second Ave., Suite 200, Waltham MA 02451



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