Mindera Assist Program Application

*PATIENT VERIFICATION

*First name

*Last name

*Email

*Zip

*Phone

INCOME INFORMATION

Question A *
Did your medical expenses exceed 7.5% of your gross household income for the last calendar year?

Yes

No

Number Of Members In Household	1	2	3	4	5	6	7	8
Total Household Income	$75,300	$102,200	$129,100	$156,000	$182,900	$209,800	$236,700	$263,600

*For each additional family member add $26,900

Question B *
Based on the table above, is your household annual gross income less than the amount corresponding with the number of persons in your household?

Yes

No

PATIENT ATTESTATION

By signing below, I confirm that I cannot afford the test and that my answers to the qualification questions above are complete, true and accurate. I also acknowledge that Mindera Health reserves the right to modify or cancel the program at any time.

Patient Name or Representative (please print)

Relationship to Patient

Signature (required)

Date

Return completed application to: Fax 858-788-9075 or by mail to Mindera Health PO BOX 120417, DEPT 0417, Dallas, TX 75312-0417

If you have questions, please contact a Mindera Health representative via email at patientsupport@minderahealth.com
Mindera Laboratory is a CLIA-certified, CAP-accredited, and HIPAA compliant laboratory (CLIA #05D2189599, CAP #8813410).
minderahealth.com