SAGA DIAGNOSTICS

# PATIENT SUPPORT PROGRAM 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 SAGA testing, are eligible for SAGA's Patient Support Program (SPSP); contact SAGA 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 eligible for a **100%** discount if my income is at or below the poverty level, **75%** discount if my income is up to 2x federal poverty level (FPL); **50%** discount if my income is 2-3x FPL; or **25%** discount 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 eligible for the discounts 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 SAGA Patient Support Program ("Program") requirements and understand that SAGA Diagnostics 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 |

Please submit your completed application by email: Billing@Sagadiagnostics.com, by fax: 919-371-0262 or by mail: SAGA Diagnostics, Attn: Billing, 860 Aviation Pkwy., Suite 300, Morrisville, NC 27560.

## Financial criteria for patient assistance

In order to meet the financial eligibility criteria for receiving SAGA testing at a reduced, you must have an annual household income of ≤400% of the current Federal Poverty Level.

**Patient Assistance Connection Financial Eligibility**
**(for uninsured or functionally uninsured patients)**

Determine the maximum household income requirement to be considered for Patient Assistance Connection by selecting your household size and then viewing the 400% column.

| 2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | | |
|---|---|---|
| Persons in family/household | Poverty Guideline | 400% |
| 1 | $15,650 | $62,600 |
| 2 | $21,150 | $84,600 |
| 3 | $26,650 | $106,600 |
| 4 | $32,150 | $128,600 |
| 5 | $37,650 | $150,600 |
| 6 | $43,150 | $172,600 |
| 7 | $48,650 | $194,600 |
| 8 | $54,150 | $216,600 |
| For families/households with more than 8 persons, add $5,500 for each additional person. | | |

*48 Contiguous States and District of Columbia Source: US Dept of Health & Human Services. Accessed 01/21/2025. Available at https://aspe.hhs.gov/poverty-guidelines.

| 2025 POVERTY GUIDELINES FOR ALASKA | | |
|---|---|---|
| Persons in family/household | Poverty Guideline | 400% |
| 1 | $19,550 | $78,200 |
| 2 | $26,430 | $105,720 |
| 3 | $33,310 | $133,240 |
| 4 | $40,190 | $160,760 |
| 5 | $47,070 | $188,280 |
| 6 | $53,950 | $215,800 |
| 7 | $60,830 | $243,320 |

| 2025 POVERTY GUIDELINES FOR ALASKA | | |
|---|---|---|
| Persons in family/household | Poverty Guideline | 400% |
| 8 | $67,710 | $270,840 |
| For families/households with more than 8 persons, add $6,880 for each additional person. | | |

*Alaska Source: US Dept of Health & Human Services. Accessed 01/21/2025. Available at https://aspe.hhs.gov/poverty-guidelines.

| 2025 POVERTY GUIDELINES FOR HAWAII | | |
|---|---|---|
| Persons in family/household | Poverty Guideline | 400% |
| 1 | $17,990 | $71,960 |
| 2 | $24,320 | $97,280 |
| 3 | $30,650 | $122,600 |
| 4 | $36,980 | $147,920 |
| 5 | $43,310 | $173,240 |
| 6 | $49,640 | $198,560 |
| 7 | $55,970 | $223,880 |
| 8 | $62,300 | $249,200 |
| For families/households with more than 8 persons, add $6,330 for each additional person. | | |

*Hawaii Source: US Dept of Health & Human Services. Accessed 01/21/2025. Available at https://aspe.hhs.gov/poverty-guidelines.