PATIENT ASSISTANCE CONSIDERATION APPLICATION

PATIENT INFORMATION

NAME	DATE OF BIRTH
STREET ADDRESS	PHONE
CITY/STATE/ZIP	EMAIL

HOUSEHOLD FINANCIAL INFORMATION (REQUIRED)

1. Annual household income after adjustments:_____yearly
2. How many people contribute to this household income? _____
3. How many people in your household? _____

DOCUMENTATION OF HOUSEHOLD INCOME (REQUIRED)

Please review the options below and provide copies that best reflect the income reported above.

1. Federal tax form (Page 1 & 2, SSN may be crossed out) from the most recent year

**A tax return is preferred but not required.*

AND/OR

2. Medicaid information (Medicaid beneficiaries)

AND/OR

3. All of the following that may apply to your household income:

- One month of paycheck statement(s) from the most recent month *Must show year-to-date gross income.
- Social Security statement of benefits (SS1099, 4506T)
- Pension/Annuity/Retirement account statements (1099R)
- Most current bank statement *Must be a complete month statement pre-printed with account owner's name. Only the account number may be crossed out.
- SNAP/government assistance (must send approval/renewal letter)

ADDITIONAL INFORMATION (OPTIONAL)

Please describe **in detail** special financial circumstances and/or medical-related expenses you would want us to consider that impacts your ability to pay for your pneumatic compression device. **Please note: medical expenses must be listed with dollar amounts to be considered.**

SIGNATURE AND APPROVAL

I certify that all information is true and correct to the best of my knowledge. I understand that Tactile Medical is relying upon this information to determine my financial need. I provide this information in strict confidence and direct that this information be used by Tactile Medical to ascertain my ability to pay for the equipment and services provided by Tactile Medical. I understand that no promise of reduction or waiver has been made and that only authorized staff may respond to this request.

SIGNATURE	DATE

TACTILE MEDICAL CANNOT PROCESS YOUR APPLICATION UNTIL ALL DOCUMENTATION OF HOUSEHOLD INCOME IS RECEIVED AND THIS DOCUMENT IS SIGNED AND DATED.

SUBMIT APPLICATION AND DOCUMENTATION:

Email: PAC@tactilemedical.com (*This email option is not an encrypted or secure method.)*

Fax: Attention: PAC Dept. 800.507.6681

Mail: Attention: PAC Dept. 3701 Wayzata Blvd, Suite 300, Minneapolis, MN 55416 USA

FOR QUESTIONS:

Phone: 866-391-0395

Tactile Medical
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Minneapolis, MN 55416 USA

Customer Care
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Toll Free Fax: 866.435.3949

Hours: 7 a.m. to 5:30 p.m. CT, Monday–Friday
tactilemedical.com

Tactile MEDICAL®