Patient Financial Assistance Program — Application Form

Complete all six steps and attach required documents. Incomplete forms will delay processing.
You can apply at any time — before your test, during processing, or after you receive a bill.

Questions?
844-563-1409 or billing@helix.com

How to submit your application: Send your completed form *with all required documents* using one of these methods:

Email: billing@helix.com
Fax: 858-777-3670

You may qualify for a discount on your Helix test — even if you have health insurance. Percentage-based discounts of up to 100% are available based on your household income and size. Submit this completed form and we will determine what you qualify for and contact you with your eligibility decision.

If you are insured, Helix will bill your insurance first. Any approved discount applies only to your remaining balance after insurance pays. If you are approved for financial assistance, your final out-of-pocket amount will not exceed Helix's current cash-pay rate for your test.

STEP 1: PATIENT INFORMATION (U.S. RESIDENTS ONLY)

First name	MI	Last name	Date of birth (MM/DD/YYYY)	Mobile phone

Email address	Employer (if applicable)

Street address	City	State	Zip code

STEP 2: HOUSEHOLD INCOME & SIZE

Number of people in your household (include yourself, spouse/partner, and all dependents you financially support)

Total gross household income per year (before taxes) *Total household income includes the following for all members of your household: gross salary, unemployment compensation, disability and workers' compensation, Social Security disability (SSDI) and/or Supplemental Security Income (SSI), public assistance (TANF, SNAP, etc.), and other income.*

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STEP 3: INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☐ NO

If YES, complete these fields below:

INSURANCE COMPANY NAME	INSURANCE PHONE NUMBER	MEMBER / POLICY ID #

GROUP #	POLICYHOLDER NAME (IF OTHER THAN SELF)

POLICYHOLDER DATE OF BIRTH

STEP 4: EXTENUATING CIRCUMSTANCES (OPTIONAL)

Check any that apply. This helps us understand your full financial situation and may qualify you for additional assistance. In Step 5, you will be asked to provide documentation for each checked item.

- ☐ Alimony and/or child support expenses over $1,000 month
- ☐ Non-local travel required for treatment (hotel, airfare) over $1,000
- ☐ Supporting family member(s) outside of my household
- ☐ Qualified for charity care with my treating physician
- ☐ Currently enrolled in short- or long-term disability leave
- ☐ Credit card debt over $5,000
- ☐ Medical expenses over $5,000
- ☐ Permanent loss of income due to my diagnosis or treatment
- ☐ Experiencing homelessness or unstable housing
- ☐ Currently receiving government assistance (SNAP, WIC, TANF, Medicaid, SSI, or similar)

Other

Is there anything else you want us to know about your financial situation

STEP 5: REQUIRED DOCUMENTATION

If you selected any extenuating circumstances in Step 4, please include supporting documentation for each in addition to proof of household income (more info below).

We need proof of household income before we can process your application. Please include at least ONE of the following:

- Most recent federal tax return: **Form 1040**, first page only
- Your **two most recent pay stubs** (dated within the last 60 days)
- Most recent **W-2 form** from your employer
- Current federal or state assistance documentation (**award letter, benefit card, or enrollment letter** for SNAP, Medicaid, SSI/SSDI, WIC, or a similar program)

If you cannot provide any of the documents above, explain your income source and why documentation is unavailable:

STEP 6: SIGNATURE & ATTESTATION

By signing below, I certify and acknowledge that I am the patient or their authorized representative with the right to act on their behalf, that all provided information is truthful and complete, that Helix may verify, audit, and request additional details to determine eligibility, that the patient will be billed if they do not qualify, that no reimbursement will be sought for waived charges, and that this program may change or discontinue without notice. I hereby acknowledge that I am neither related to, nor employed by, the physician who ordered the testing.

Patient name or personal representative (print)	Relationship to patient
Signature	Date (MM/DD/YYYY)

Income values are pre-tax and based on 2026 Federal Guidelines published by the U.S. Department of Health and Human Services (aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines).

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