UNITY POWERED BY BillionToOne

FINANCIAL ASSISTANCE FORM US Residents Only

Form not applicable for patients with US federal or state-funded health insurance (e.g., Medicaid, managed Medicaid, Tricare).
Please contact Support at 650.460.2551 if you have federal or state-funded health insurance.

PATIENT INFORMATION *Shaded fields must be completed*

First Name | MI | Last Name | Date of Birth (MM-DD-YYYY)

Email Address | Phone | # of People in Household | Annual Household Income (Pre-Tax)

Street Address | Apt / Unit / Suite | City | State | Zip Code

ASSISTANCE LEVEL

If your total yearly pre-tax household income is less than the amounts below, depending on your household size, you may qualify for reduced pricing for the UNITY™ test. If your out-of-pocket financial responsibility is above the test costs below, we will cap it at a reduced price.

Income values are pre-tax and based on 2019 poverty guidelines: *https://aspe.hhs.gov/poverty-guidelines*.
For households larger than 8, please contact our Customer Support.

# of people in household	**$0** test cost	**$99** test cost	**$199** test cost
(including current pregnancy)	if your total household income is equal to or less than	if your total household income is equal to or less than	if your total household income is equal to or less than
2	$16,910	$33,820	$67,640
3	$21,330	$42,660	$85,320
4	$25,750	$51,500	$103,000
5	$30,170	$60,340	$120,680
6	$34,590	$69,180	$138,360
7	$39,010	$78,020	$156,040
8	$43,430	$86,860	$173,720

PATIENT ATTESTATION *Sign and date*

I hereby certify that the information provided above is true and accurate. I also certify that I do not carry any U.S. federal and state-funded health insurance (e.g., Medicare, Medicaid, Tricare, Medicare Advantage). I understand and agree that BillionToOne reserves the right, at any time and without notice, to modify the application form, to modify or terminate this program, to audit my information or to request additional information.

Patient Signature

Date (MM-DD-YYYY)

CLINIC INFORMATION *Shaded fields must be completed*

Clinic Name

Clinic Phone | Clinic Fax

Clinic Address

INSTRUCTIONS

Complete and place this form in the box along with the sample, or FAX it to 833.915.0146.