PEACHTREE ALLERGY AND ASTHMA CLINIC PATIENT ASSISTANCE PROGRAM
APPLICATION FORM

Peachtree Allergy may provide financial assistance to eligible uninsured and underinsured patients who otherwise would experience financial hardship resulting from of the cost of necessary long-term treatment programs.

Size of Household:_____ persons

Total Household Income for the previous calendar year: $_____

Attestation: I certify that the above statement of my household size and total annual household income for the previous calendar year is true, and that without assistance the cost of medical services needed at Peachtree Allergy would be beyond my ability to pay or would create a financial hardship.
I will provide IRS Form 1040 or other documentation of information indicated above, upon request.

Briefly explain any special circumstances resulting in financial hardship for applicant and / or family:

_____

_____

*Insurance status of patient--

- ❒ No health insurance; OR
- ❒ Copy of Insurance card (both sides) attached

*I authorize e-mail communications to the following e-mail address: _____

*OK to leave detailed messages at the following phone number: _____

*Best time to contact me by phone Monday thru Friday during 9AM thru 5PM hours: _____

*_____ *_____
Signature of patient or authorized representative **Date Signed**

Response is necessary for all lines above marked with *

General conditions of the Peachtree Allergy Patient Assistance Program:

◆ Applications will considered only for applicants with household income < 400% of current federal poverty guidelines (https://aspe.hhs.gov/poverty-guidelines)

Household size	Annual income-400% of poverty guidelines
1	$47,520
2	$64,080
3	$80,640
4	$97,200

◆ May assist only with the cost of specified services associated with a long-term planned program of treatment
◆ Must be arranged in advance of provision of the specified services.
◆ All patient responsibility amounts must be paid at the time of each service
◆ Available only for services provided directly by Peachtree Allergy

Questions?—call patient assistance program coordinator at 770-832-1984 extension 233

Fax completed and signed form with copy of insurance card (if applicable) to:
Peachtree Allergy Patient Assistance Program Coordinator fax 770-832-9235