NORTHSTAR

FINANCIAL ASSISTANCE FORM

for Northstar Select™ & Northstar Response™ liquid biopsy tests

Place completed form in the sample collection box, or fax it to 833.874.0918.

For US only. Not applicable for patients with federal or state-funded health insurance (e.g., Medicaid, managed Medicaid, Tricare).
Please contact Support at 833.537.1819 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 Northstar tests.

Income values are pre-tax and based on 2023 poverty guidelines: https://aspe.hhs.gov/poverty-guidelines.
For households larger than 8, please contact our Customer Support.

# of people in household	100% discount	75% discount	50% discount
	if your total total household income is ≤2x FPL	if your total household income is >2x and ≤4x FPL	if your total household income is >4x and ≤6x FPL
1	$29,160	$58,320	$87,480
2	$39,440	$78,880	$118,320
3	$49,720	$99,440	$149,160
4	$60,000	$120,000	$180,000
5	$70,280	$140,560	$210,840
6	$80,560	$161,120	$241,680
7	$90,840	$181,680	$272,520
8	$101,120	$202,240	$303,360

EXTENUATING CIRCUMSTANCES *Select if applicable*

BillionToOne will also consider any extenuating circumstances when evaluating your personal situation.

- ☐ Retired (i.e., fixed income)
- ☐ Short or long-term disability
- ☐ Significant medical expenses
- ☐ Supporting family member(s) outside of household
- ☐ Alimony and/or child support
- ☐ Loss of income due to diagnosis or treatment (if both please explain)
- ☐ Non-local travel expenses for treatment (e.g., hotel, airfare, etc.)
- ☐ Other ____________________

CLINIC INFORMATION *Shaded fields must be completed*

Clinic Name

Clinic Phone | Clinic Fax

Clinic Address

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 or Representative Signature | Date (MM-DD-YYYY)

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