Advanced Respiratory, Inc. A Hillrom Company
1020 West County Road F, Saint Paul, MN 55126-9864
Telephone (844) 732-2778 ▪ **Confidential Fax (888) 295-1860**

PATIENT APPLICATION FOR FINANCIAL OBLIGATION WAIVER

This application is required for persons interested in receiving assistance from Advanced Respiratory, Inc.
Please complete ALL sections of this form and return with all required documentation.

A representative will contact you once your completed application has been received and a determination has been made regarding your application. If you have any questions or concerns while completing this application, please contact us at the toll-free number listed above.

PATIENT INFORMATION

Name _____ Account Number _____
If not known, leave blank

Address _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone Number _____ Email Address _____

Number of Persons in Household _____ (all persons should be identified as tax filers or dependents on tax forms)

Is Patient a Citizen of the U.S.? Yes _____ No _____ If No, please submit a photocopy of Legal Resident Card.

Is Patient claimed on someone else's taxes? Yes _____ No _____

PRODUCT INFORMATION

Please check the Product in which you are seeking Financial Assistance

_____ The Vest® Airway Clearance System _____ Monarch® System _____ Volara™ System

_____ Life2000® Ventilation System _____ Synclara™ Cough System
Co-pay, co-ins, and deductible only

PROOF OF INCOME DOCUMENTATION REQUIRED

Please check which Proof of Income Documentation you will be providing (Primary or Secondary)

___ **PRIMARY PROOF OF INCOME**
If the patient is claimed as a dependent on someone else's taxes (such as a parent or spouse), then the tax forms of that tax filer are required.
___ A copy of your most recent year's Federal 1040 Income Tax return, if filed.

___ **SECONDARY PROOF OF INCOME (IF PRIMARY DOES NOT APPLY)**
If the patient is not required to file taxes and is not claimed as a dependent on someone else's taxes, then you must submit other documentation as proof of income.
___ **PAST TWO MONTHS OF COMPLETE BANK STATEMENTS PLUS, ONE OF THE FOLLOWING:**
___ Most recent Social Security statement
___ Most recent statement from a State or County Government Agency qualifying you for public assistance
___ Disability Statement
___ VA Benefit Letter or Pension Letter

RELEASE AND CERTIFICATION

I am submitting the information above for the purpose of obtaining financial assistance from Advanced Respiratory, Inc. I certify that the information provided is true and correct to the best of my knowledge. I understand that the information is in strict confidence and will be used only by Advanced Respiratory, Inc. to ascertain my ability to pay for products and services provided by Advanced Respiratory, Inc.

I understand that this application is subject to the guidelines of The Patient Assistance Program and that eligibility will be determined by the program guidelines and criteria. By signing below, I certify that everything I have stated on this application and on any attachments is true and complete.

_____ _____
Signature of Applicant Date