



Hillrom™

Advanced Respiratory, Inc. A Hillrom Company

1020 West County Road F
Saint Paul, MN 55126-9864
Telephone (800) 426-4224 • 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., A Hillrom Company. Please complete ALL sections of this form and include a II required documentation.

A Financial Representative will contact you promptly once your application has been received and a determination has been made regarding assistance to be offered. If you have any questions or concerns while completing this application, please feel free to contact us at the toll-free number listed above.

PATIENT INFORMATION

Name, Account Number, Address, Date of Birth, City, State, Zip, Telephone Number, Number of Persons in Household

Is Patient a Citizen of the U.S.? Yes No If No, please submit photocopy of Legal Resident Card.
Is Patient claimed on someone else's taxes? Yes No

PRODUCT INFORMATION

Please check the box for which Product Type applies

The Vest® Airway Clearance System, Monarch® System, The Volara™ System, Life 2000® Ventilation System, Vita I Cough® or The Synclara™ Cough System

Do you currently have a Device? Yes No

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 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