Genentech® Access to Care Foundation (GATCF) Patient Financial Attestation

Phone (800) 530-3083 - Fax (650) 225-1366

Total household income for the previous calendar year: $ ____________

Read the following Attestation and ***FAX*** *to GATCF at* ***(650) 225-1366***

I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products.

I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes.

Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate.

By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Complete the lines below (Required for Eligibility Review):

(*) Signature of Patient or Authorized Representative: ____________________

Print Patient's First and Last Name: ____________________

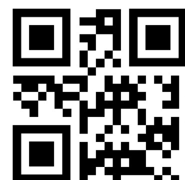
Patient's Date of Birth:__________ Today's Date: ____________________

(*) Print Authorized Representative Name (if signed above): ____________________

(*) Authorized Representative Relationship to Patient (if applicable): ____________

(*) If the patient is an unemancipated minor, or otherwise incapacitated (physically or mentally)

For purposes of this Attestation Form, "I," "you," or "your" means the Patient, the patient's Authorized Representative, or the patient's Estate executor/administrator.



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