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

Phone (866) 681-3329 - Fax (866) 681-3338

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Total Household Income for the past calendar year: $__________________________

Read the following Attestation and ***FAX*** *to GATCF at* ***(866) 681-3338***

I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my household annual Adjusted Gross Income (AGI) for the past calendar year is true. I do not have the financial resources to pay for Genentech products.

I know 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 information in a timely manner, upon such request. I will notify GATCF immediately if my insurance or financial situation changes.

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

By signing this attestation, I certify 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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