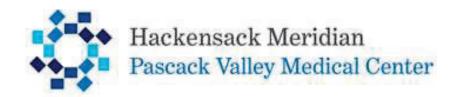


APPLICATION FOR UNCOMPENSATED CARE

Patient Name (Last, First, MI)		Social Security Number				Date of Birth	
Street Address	et Address		City		State		Zip
Home Tel #			Ce	ell Tel #			
Employer Name and Address							Work Tel #
LIST ANY OTHER INCOM	ME BELOW		TOTAL FAN	MILY GROSS IN	NCOME		,
Welfare \$	Unemployment/Disability \$		Last Month/ 4 wks x 13 \$		Last 3 Months		st 12 Months
Social Security \$	Security Workers Comp \$		Total Annual Income Family Size \$ List Immedi			nte Family Names and Dates of Births	
Pension \$	· ·						
Rental Income \$	List Any other Income						
LIST ALL ASSETS	Ψ						
Savings Account \$	Checking Account \$		Annuities/Scholarships/Gra \$		holarships/Grants	Pre-paid direct deposit Debit Cards \$	
IRA or Retirement Acc \$	ts Stocks/Bonds/CD's			Other Assets \$		Total Assets	
Categorically Ineligible for Medicaid				High Income Not Disabled		Ineligible Alien Medicaid Non-Compliant	
Value of Real Estate in	USA and or in	another Coun	try (if other t				
Health Insurance Carrier Name			Policy #				Group#
Insurance Address			City		State	Zip	
Amount of Bill Paid by Insurance Amount NOT Paid by Insurance Date of Service							rvice
I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to Hackensack Meridian Health the amount recovered for hospital charges. I understand that is my obligation to provide the hospital with proof of determination for Medicaid. I understand that this application is made so that the hospital can judge my eligibility for uncompensated services under the State Department of Health Uncompensated Care Program. Based on the established criteria on file in the hospital, if any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.							
XDate							ate
Applicant's Signature Applicant's Signature							
DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)							
ELIGIBILITY DETE	RMINATION						
Date Application Recei	reived Income Verified Yes No		Application ApprovedPending Medicaid		Pending Income Verification Pending assets		
Application Denied: REASON:							
Percentage of Eligibility% Signature of Person Making Determination Date:							Date:
NOTE: IF APPLICATION IS DENIED YOU MAY REAPPLY FOR FUTURE SERVICES							



Patient Name:	Acct #
CERTIFICAT	ΓΙΟΝΣ
A. I certify that I have no health coverage available to cover	r the cost of this service.
B. Circle marital status: single, married, divorced, widowed	d I have (#) minor children
C. I certify that am married and separated and have no type	financial ties with my spouse since
Signed:	<u> </u>
D. I certify that I receive no child support/alimony from my Signed:	•
E. I certify that I have had no income since://	_
F. At the time of service I was employed by:	
Date of hire:/ My gross income was \$	Weekly/Bi-Weekly/Monthly/Yearly
I received other income from	\$ Weekly/Bi-Weekly/Monthly/Yearly
G. I certify that I did/did not file income tax for the year of	If no, state reason for not filing:
H. I certify that I have no type of assets.	
Signed:	Relationship to patient:

I. I certify that I have resided at (Address)	
I live by myself or with	
J. I certify that I have been a resident of the State o in any other state or county and have every inten	f New Jersey since I have no residency tion on continuing my residency in New Jersey.
K. I attest that I am homeless and have been since I do/ I do not occasionally stay at a local shelter. Name/Address of Shelter: I do/ I do not have identification.	
Signed:	
L. I am making this Affidavit in order to apply for C <u>I understand that the information, which I have subred</u> <u>Meridian Health and the Federal or State Government this application for Charity Care, subject me liable for 26:2H-18.63.</u>	nitted, is subject to verification by Hackensack nts. Willful misrepresentation of these facts will negate
If so requested by Hackensack Meridian Health, I will appayment of the hospital bill if I qualify for assistance.	pply for government or other medical assistance for
I certified that the information with regard to my inc best of my knowledge.	come, family size and assets is true and accurate to the
Signed: Patient / Spouse / Parent / Guardian	Date:
Witness:	Date: