Hackensack Meridian
Pascack Valley Medical Center

APPLICATION FOR UNCOMPENSATED CARE

Patient Name (Last, First, MI)	Social Security Number		Date of Birth
Street Address	City	State	Zip
Home Tel #	Cell Tel #		
Employer Name and Address			Work Tel # ( )

LIST ANY OTHER INCOME BELOW | **TOTAL FAMILY GROSS INCOME**

Welfare $	Unemployment/Disability $	Last Month/ 4 wks x 13 $	Last 3 Months $	Last 12 Months $
Social Security $	Workers Comp $	Total Annual Income $	Family Size____ List Immediate Family Names and Dates of Births	
Pension $	Alimony / Child Support $			
Rental Income $	List Any other Income $			

LIST ALL ASSETS

Savings Account $	Checking Account $	Annuities/Scholarships/Grants $	Pre-paid direct deposit Debit Cards $
IRA or Retirement Accts $	Stocks/Bonds/CD's $	Other Assets $	Total Assets $

Categorically Ineligible for Medicaid _____High Income _____ Ineligible Alien
_____Not Disabled _____ Medicaid Non-Compliant

Value of Real Estate in USA and or in another Country (if other than your one family home that you reside in) $_____

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**

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.

X _____ **Date** _____

Applicant's Signature

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

ELIGIBILITY DETERMINATION

Date Application Received Income Verified ___ Yes ___ No ____Application Approved ____ Pending Income Verification
____ Pending Medicaid ____ Pending assets

Application Denied: _____ REASON:

Percentage of Eligibility _____**%** Signature of Person Making Determination Date:

NOTE: IF APPLICATION IS DENIED YOU MAY REAPPLY FOR FUTURE SERVICES

Hackensack Meridian
Pascack Valley Medical Center

Patient Name:_____ Acct #_____

CERTIFICATIONS

___A. I certify that I have no health coverage available to cover the cost of this service.

___B. Circle marital status: single, married, divorced, widowed I have (#) _____ minor children

___ C. I certify that am married and separated and have no type financial ties with my spouse since_____

Signed: _____

___ D. I certify that I receive no child support/alimony from my former spouse.

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 of New Jersey since _____. I have no residency in any other state or county and have every intention 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 Charity Care.

I understand that the information, which I have submitted, is subject to verification by Hackensack Meridian Health and the Federal or State Governments. Willful misrepresentation of these facts will negate this application for Charity Care, subject me liable for all charges and civil penalties pursuant to N.J.S.A. 26:2H-18.63.

If so requested by Hackensack Meridian Health, I will apply for government or other medical assistance for payment of the hospital bill if I qualify for assistance.

I certified that the information with regard to my income, family size and assets is true and accurate to the best of my knowledge.

Signed: _____ Date: _____
Patient / Spouse / Parent / Guardian

Witness: _____ Date: _____