



APPLICATION FOR UNCOMPENSATED CARE

Patient Name (Last, First, MI)	Social Security Number	Date of Birth
Street Address	City	State Zip

Home Tel#	Cell Tel#
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Employer Name and Address	Work Tel# ()
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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#
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Insurance Address	City	State	Zip
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Amount of Bill Paid by Insurance	Amount NOT Paid by Insurance	Date of Service
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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	___ Application Approved	___ Pending Income Verification
	Yes No	___ Pending Medicaid	___ Pending assets

Application Denied: _____ REASON: _____

Percentage of Eligibility _____%	Signature of Person Making Determination	Date:
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NOTE: IF APPLICATION IS DENIED YOU MAY REAPPLY FOR FUTURE SERVICES

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 I*
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: _____
Patient / Spouse / Parent / Guardian

Date: _____

Witness: _____

Date: _____