Atlantic Health System

MORRISTOWN MEDICAL CENTER
100 Madison Avenue Interoffice Box 111
Morristown NJ 07960

__ OVERLOOK MEDICAL CENTER
99 Beauvoir Avenue Interoffice Box 237
Summit, NJ 07902

__NEWTON MEDICAL CENTER
175 High Street
Newton, NJ 07860

__ CHILTON MEDICAL CENTER
97 W. Parkway ATTN: Financial Counseling
Pompton Plains, NJ 07444

__HACKETTSTOWN MEDICAL CENTER
651 Willow Grove Street
Hackettstown, NJ 07840

It is your responsibility to submit all the documents requested along with your completed financial assistance application and certification. Both the patient and the spouse must each complete a certification page.

Please note that documents other than the ones listed below may be requested and necessary to process your application. Please note if you are over 18yrs old but under the age of 22 and enrolled as a full time student, you will need to provide your identification as well as your parents or legal guardian and siblings. You are also required to provide your parents or legal guardian income and assets.

- One form of personal identification for each family member, including patient, spouse and minor dependents. Acceptable forms of ID include: U.S. driver's license, passport, social security card, birth certificate, alien registration card or employee ID.

- Proof of Address as of (date of service/application) _____. Acceptable forms of proof of address immediately prior to date of service/application include: lease or utility bill. Piece of mail with patient name and address is also acceptable but must be post marked within 2 months prior to the date of service/application. Nothing after the date of service will be accepted. P.O. Box addresses are not acceptable.

- Documentation of gross income for one month, three months, or one year immediately prior to date of service/application for both patient and spouse. Documentation may include the following:
  - Pay stubs from employer (4 consecutive weeks immediately prior to _____)
  - Unemployment benefit information (4 consecutive weeks immediately prior to _____)
  - Social Security Award letter or other benefits statement showing pension, disability, child support, alimony, annuity, etc…
  - Typed letter from employer on company letterhead stating length of employment, how often paid and the amount paid gross. (Cannot state approximate amount must be exact and must say the word "gross" on the letter)
  - Accountant's statement of adjusted gross income if the patient and/or spouse are self-employed. Must include tax ID and must be signed by the person preparing the document. Must be exactly one month, three months, or a year prior to date of service or application. Here are the exact dates needed: _____/_____/_____ to _____/_____/_____.
  - Statement of support from the person providing room and board if the patient and spouse receive no income.

- Most recent bank statement (checking & savings) for both patient and spouse as of (date of service/application) _____. We will also need balances of all retirement funds, trust funds, certificate of deposit (CD), value of equity in homes owned other than primary residence, stocks, bonds, IRA and any other liquid assets.

- Most recently filed tax return including all schedules and W2's.

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APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name	Social Security Number	Date of Birth

Street Address	City	State	Zip

Employer	Home Phone	Gross Pay

Other Income — Family Gross Income (As of Date of Service)

Welfare $	Unemployment $	Last 12 Months	Last 3 Months	ANNUALIZED
Soc Sec $	Work/Comp $	Family Size	Names and Dates of Birth	
VA Pension $	Alimony $			
Rental $	Other $			

Liquid Assets

Savings Account	Checking Account	CD'S	T-BILLS
IRA	Negotiable Paper/Corporate Stock	Other	Total Liquid Assets

Category Ineligible for Medicaid
____ High Income
____ Not Disabled
____ Ineligible Alien

Value of Real Estate
$

Health Insurance Carrier Name		Policy Number	
Street 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 make application 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 the hospital 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.

_____ Date of Request

_____ 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 Determination
___Application Denied		

REASON:

	Signature of Person Making Determination Date
Percentage of Eligibility _____%	

NOTE IF APPLICATION IS DENIED YOU MAY REAPPLY FOR FUTURE SERVICES

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To be completed by the patient

C E R T I F I C A T I O N S

___ A. I have (#) _____ minor children.

___ B. I am: Single, Married, Divorced, Widow, Separated and have no Financial ties with my spouse.

___ C. I receive no child support/alimony from my former spouse/other.

Signed: _____

___ D. I certify that I have had no income from: ____/____/_____ to ____/____/_____.

Signed: _____

___ E. At the time of service I was ____ unemployed or ____ employed by: _____

Date of Hire: ____/____/_____ I was receiving $ _____ Weekly, Bi Weekly, Monthly, Yearly.

Other income received from _____ $ _____ Weekly, Bi Weekly, Monthly, Yearly.

___ F. I certify that I have no assets.

Signed: _____

___ G. I attest that I am homeless and have been since ____/____/_____. I do/ I do not occasionally stay at a local shelter.
I do/ I do not have identification.
Name/Address of Shelter: _____

Signed: _____

___ H. I attest that I have not filed any income tax return for the year _____ because _____.

___ I. I certify that I had no health coverage.

Signed: _____

___ J. I have resided at _____

By myself / with _____

___ K. I have been a resident of the State of New Jersey since _____. I have no residency in any other state or country and have every intention on continuing my residency in New Jersey.

Signed: _____

___L. I am not a resident of the State of New Jersey. I was admitted into the hospital under emergency circumstances.

Signed: _____

__ M. 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 Atlantic Health System and the Federal or State Governments.
Willful misrepresentation of these facts will negate the hospitals right to receive reimbursement for any charges not covered by a third party insurance carrier.
If so requested by Atlantic Health System 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: _____

Witness: _____ Date:_____

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.If married, to be completed by spouse

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