Cooper University Health Care

New Jersey Hospital Care Assistance Program

Proof of identification, Proof of Income, and Proof of Assets must accompany this Application.

Patient Name: _____

Soc. Sec. No. _____-_____-_____

Date of Birth: _____

Req. Date of Service/D.O.S. _____

Home Address: _____

Name of Guarantor _____

_____

U.S. Citizenship _____**Yes** _____**No** _____ **Pending Application**

Phone: _____

Proof of NJ Residency _____**Yes** _____**No**

Family Size _____

Eligible for Medicaid _____**Yes** _____**No**

Name and ages _____

Sources of Income

Salary/Wages (*gross*)	**$_____Month**
Public Assistance	**$_____Month**
Soc. Sec. Benefits	**$_____Month**
Unemployment & Worker's Comp.	**$_____Month**
Veterans Benefits	**$_____Month**
Alimony/Child Support	**$_____Month**
Other Monetary Support	**$_____Month**
Pension	**$_____Month**
Insurance/Annuity Payments	**$_____Month**
Dividends/Interest	**$_____Month**
Rental Income	**$_____Month**
Net Business Income (*self employed/* *Verified by Independent source)*	**$_____Month**
Other *(strike, benefits, training stipends, Military Family allotment, income from estates and trust)*	**$_____Month**

Assets Criteria

Individual Assets	**$_____**
Family Assets	**$ _____**
Cash	**$ _____**
Savings Account	**$ _____**
Checking Account	**$ _____**
Cert. Of Dep/I.R.A.	**$ _____**
Real Estate Equity *(Other Than Primary Residence)*	**$ _____**
Other Assets ***(Treasury Bills, Negotiable paper, corp. stock/bonds)***	**$ _____**
Total Family Income	**$_____**
Total Assets	**$_____**

I understand that the information, which I submit, is subject to verification by the appropriate health care facility and the federal or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties. If so requested by the health care facility, I will apply for governmental or private medical assistance for payment of the hospital bill, I certify that the above information regarding my family size, income, assets are true and correct. I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

Date of Application _____ **Signature:** _____
(Patient/Guarantor)

FOR OFFICE USE ONLY: Approval Rating _____**100%**_____**80%**_____**60%**_____**40%**_____**20%**_____**30%rule**

Issue Date: _____ **Expiration Date:** _____

Financial Counselor _____ **Patient MPI:** _____
(Signature of Hospital Representative)