Cooper University Health Care

Financial Assistance Policy Application

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			**Assets Criteria**	
Salary/Wages (*gross*)	**$**	**Month**	**Individual Assets**	**$**
Public Assistance	**$**	**Month**	**Family Assets**	**$**
Soc. Sec. Benefits	**$**	**Month**	**Cash**	**$**
Unemployment & Worker's Comp.	**$**	**Month**	**Savings Account**	**$**
Veterans Benefits	**$**	**Month**	**Checking Account**	**$**
Alimony/Child Support	**$**	**Month**	**Cert. Of Dep/I.R.A.**	**$**
Other Monetary Support	**$**	**Month**	**Real Estate Equity** *(Other Than Primary Residence)*	**$**
Pension	**$**	**Month**	**Other Assets** ***(Treasury Bills, Negotiable paper, corp. stock/bonds)***	**$**
Insurance/Annuity Payments	**$**	**Month**		
Dividends/Interest	**$**	**Month**	**Total Family Income**	**$**
Rental Income	**$**	**Month**	**Total Assets**	**$**
Net Business Income (*self employed/* *Verified by Independent source)*	**$**	**Month**		
Other *(strike, benefits, training stipends, Military Family allotment, income from estates and trust)*	**$**	**Month**		

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)