Atlantic Rehabilitation Institute, LLC

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.

Atlantic Rehabilitation Institute, LLC

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:

Percentage of Eligibility %	Signature of Person Making Determination Date

NOTE IF APPLICATION IS DENIED YOU MAY REAPPLY FOR FUTURE SERVICES

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 _____ .

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 Rehabilitation Institute, LLC 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 Rehabilitation Institute 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: _____

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 Rehabilitation Institute, LLC 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 Rehabilitation Institute 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:

.

CERTIFICATIONS

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 _____.

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 Rehabilitation Institute, LLC 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 Rehabilitation Institute 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: _____

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 Rehabilitation Institute, LLC 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 Rehabilitation Institute 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: _