Enclosed please find your Charity Care/Financial Aid application forms.

You may apply for Financial Aid within 1 year after discharge from the hospital or receipt of outpatient care.

Charity Care is available to New Jersey residents who are uninsured, underinsured, or ineligible for state and federal programs.

To qualify you must meet both the income and assets eligibility criteria.

Charity Care covers hospital care. The program does not apply to physicians or other providers who independently bill for their services.

- Please fill out and sign the application
- Attach copies of all required documents.
- All documentation is based on date of service.
- Your initial or first Date of Service is_________________________
- If you are 21 years of age or younger and a full time college student, your parent or guardian must fill out the application and provide the necessary supporting documents. Please provide proof of your student status.

If you have any questions regarding the application or documentation that is required to apply, please call a financial counselor at 732-902-7080. Counselors are available Monday to Friday from 8:00 am – 4:00 pm.

(    ) JERSEY SHORE UNIVERSITY MEDICAL CENTER (JSUMC)  
PATIENT FINANCIAL SERVICES  
1945 STATE ROUTE 33  
NEPTUNE, NJ 07753

(    ) SOUTHERN OCEAN MEDICAL CENTER (SOMC)  
PATIENT FINANCIAL SERVICES  
1140 ROUTE 72 WEST  
MANAHAWKIN, NJ 08050

(    ) OCEAN MEDICAL CENTER (OMC)  
PATIENT FINANCIAL SERVICES  
425 JACK MARTIN BLVD  
BRICK, NJ 08724

(    ) RARITAN BAY MEDICAL CENTER – PERTH AMBOY (RBMC-PA)  
PATIENT FINANCIAL SERVICES  
530 NEW BRUNSWICK AVE  
PERTH AMBOY, NJ 08861

(    ) RIVERVIEW MEDICAL CENTER (RMC)  
PATIENT FINANCIAL SERVICES  
1 RIVERVIEW PLAZA  
RED BANK, NJ 07701

(    ) RARITAN BAY MEDICAL CENTER – OLD BRIDGE (RBMC-OB)  
PATIENT FINANCIAL SERVICES  
1 HOSPITAL PLAZA  
OLD BRIDGE, NJ 08857

(    ) BAYSHORE COMMUNITY HOSPITAL (BCH)  
PATIENT FINANCIAL SERVICES  
727 NORTH BEERS STREET  
HOLMDEL, NJ 07733

6.26.17
To further assist us in processing your application for charity care, please provide copies of the documents listed below which apply to your situation. If the appropriate documentation listed below is not provided or your application is incomplete, we will not be able to process your application. All required documents are based on your Date of Service. Date of Service means the first day you were actually in the hospital.

Insurance Cards, please copy the front and back

Personal ID for patient, spouse, children under 18, and full time college students under 21.
- Please choose one for each member of your family: driver’s license, birth certificate, Social Security card, passport

Asset statements that include the balance on your date of service
- Checking, savings, and debit card account statements
- If the statement is a printout, have it stamped and signed by the financial institution representative.
- Deposits over your reported income may require an explanation.
- Current documentation for any CD’s, IRA’s, 401K’s, stocks or bonds.

Proof of Income for the one month prior to the date of service
- Proof of earned income, including pay stubs or a written signed statement of gross earnings from your employer on business letterhead.
- If you are self employed, a profit and loss statement signed by an accountant is required.
- Proof of unearned income, including but not limited to retirement pension, child support, alimony, VA benefits, Social Security award letter, SSI Award letters for all family members, unemployment or State Disability record or other financial contributions.
- Complete copy of your Tax Return for the prior year. If you did not file please call 1-800-829-1040 to request a verification of non filer status.

Proof of Residence prior to the date of service
- Must show street address – NOT a PO Box
- Please choose one of the following: driver’s license, copy of lease, utility bill, letter of support, dated mail with your name and address issued prior to date of service

Patient’s attestation: (sign and date all that apply).
- Spouse’s attestation if married (sign and date all that apply).

Have the enclosed Letter of Support signed by the person with whom you reside (other than a spouse) that is helping to support you.

Please mail your application and documents to:

Jersey Shore University Medical Center
Financial Assistance
1945 State Route 33
Neptune, NJ 07753-9986
New Jersey Hospital Care Assistance Program
Application for Participation

( ) JSUMC  ( ) OMC  ( ) RMC  ( ) BCH  ( ) SOMC  ( ) RB-PA  ( ) RB-OB

SECTION I – PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>PATIENT NAME (LAST, FIRST, M.I.)</th>
<th>SOCIAL SECURITY</th>
<th>DATE OF BIRTH</th>
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<tbody>
<tr>
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<thead>
<tr>
<th>DATE OF APPLICATION</th>
<th>DATE OF SERVICE</th>
<th>PREFERRED LANGUAGE</th>
<th>PREGNANT</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ YES</td>
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<tr>
<th>STREET ADDRESS OF PATIENT</th>
<th>TELEPHONE/CELL NUMBER</th>
<th>CITY, STATE, ZIP CODE</th>
<th>FAMILY SIZE</th>
<th>MARITAL STATUS</th>
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<tr>
<th>US CITIZENSHIP</th>
<th>PROOF OF N.J. RESIDENCY</th>
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<tr>
<td>□ YES</td>
<td>□ YES</td>
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<tr>
<td>□ NO</td>
<td>□ NO</td>
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<tr>
<td>□ LEGAL RESIDENT SINCE: ____________</td>
<td>□ EMERGENCY SERVICES</td>
</tr>
</tbody>
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<tr>
<th>NAME OF GUARANTOR (If other than Patient)</th>
<th>INSURANCE COVERAGE:</th>
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<tbody>
<tr>
<td></td>
<td>□ YES</td>
</tr>
<tr>
<td></td>
<td>NAME:</td>
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</table>

<table>
<thead>
<tr>
<th>OTHER FAMILY MEMBERS</th>
<th>RELATIONSHIP</th>
<th>BIRTHDATE</th>
<th>PREGNANT</th>
<th>INSURANCE COVERAGE</th>
</tr>
</thead>
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SECTION II- ASSET CRITERIA

ASSETS INCLUDE:

A. Savings Accounts
   ________________________________

B. Checking Accounts
   ________________________________

C. Certificates of Deposit / IRA
   ________________________________

D. Equity in Real Estate (other than primary residency)
   ______________________________________

E. Other Assets, 401K, Stocks and Bonds
   ________________________________

F. TOTAL
   ________________________________

* FAMILY SIZE INCLUDES SELF, SPOUSE AND ANY MINOR CHILDREN. A PREGNANT WOMAN IS COUNTED AS TWO FAMILY MEMBERS.
SECTION III- INCOME CRITERIA

When determining eligibility for hospital care assistance, a spouse’s income and credits must be used for an adult parent(s)’s (s) Income and credits must be used for a minor child. Proof of income must accompany this Application. Income is based on the calculation of either twelve months, three months, one month or one week of income prior to the date of service.

<table>
<thead>
<tr>
<th>EMPLOYER NAME:</th>
<th>TOTAL INCOME</th>
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<td>$</td>
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SOURCES OF INCOME:

A. Salary / Wages before Deductions ________________________________
B. Public Assistance ____________________________________________
C. Social Security/Disability Benefits ______________________________
D. Unemployment & Workman’s Comp. _________________________________
E. Veteran’s Benefits ____________________________________________
F. Alimony / Child Support ________________________________________
G. Other Monetary Support ________________________________________
H. Pension Payments _____________________________________________
I. Insurance or Annuity Payments _________________________________
J. Dividends / Interest __________________________________________
K. Rental Income _______________________________________________
L. Net Business Income __________________________________________
M. Other (Strike benefits, training stipends, Military family allotment, estates or trust) ________________________________

Other source of income: ____________________________________________

SECTION IV – CERTIFIED BY APPLICANT

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 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 status, income and assets is 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.

SIGNATURE OF PATIENT OR GUARDIAN DATE

FOR OFFICE USE ONLY: Responsibility No insurance coverage ____________________ %

After insurance coverage ____________________ %

DATE APPROVED: ____________________ Effective: ____________________ Terminates: ____________________

Evaluator’s Signature: ____________________
PATIENT ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION:

1. I attest that as of ______________________ I have NOT received any income.
   _______________________________
   (Patient / Responsible Party)     Relationship                        DATE

2. I attest that I have NO ASSETS (Bank accounts, CD’s, etc.) through myself or any other party.
   _______________________________
   (Patient / Responsible Party)     Relationship                        DATE

3. I attest that I am HOMELESS and have been HOMELESS since ______________________
   _______________________________
   (Patient / Responsible Party)     Relationship                        DATE

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the
   outstanding amount of my bills.
   _______________________________
   (Patient / Responsible Party)     Relationship                        DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE PATIENT/RESPONSIBILITY PARTY

5. I ATTEST THAT I AM/WAS A NEW JERSEY RESIDENT AT THE TIME SERVICES WERE RECEIVED AND
   that I INTEND TO REMAIN A RESIDENT OF NEW JERSEY.
   _______________________________
   (Patient / Responsible Party)     Relationship                        DATE

6. I AFFIRM THAT ALL INFORMATION GIVEN ON THIS ATTESTATION IS TRUE,
   COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
   _______________________________
   (Patient / Responsible Party)     Relationship                        DATE

____________________________________________________________________
Interviewer
SPOUSE ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION:

1. I attest that as of ______________________ I have NOT received any income.
   DATE

   ___________________________   ___________________________
   (Spouse / Responsible Party)   Relationship   DATE

2. I attest that I have NO ASSETS (Bank accounts, CD’s, etc.) through myself or any other party.

   ___________________________   ___________________________
   (Spouse / Responsible Party)   Relationship   DATE

3. I attest that I am HOMELESS and have been HOMELESS since ______________________

   ___________________________   ___________________________
   (Spouse / Responsible Party)   Relationship   DATE

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

   ___________________________   ___________________________
   (Spouse / Responsible Party)   Relationship   DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE PATIENT/RESPONSIBILITY PARTY

5. I ATTEST THAT I AM/WAS A NEW JERSEY RESIDENT AT THE TIME SERVICES WERE RECEIVED AND that I INTEND TO REMAIN A RESIDENT OF NEW JERSEY.

   ___________________________   ___________________________
   (Spouse / Responsible Party)   Relationship   DATE

6. I AFFIRM THAT ALL INFORMATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

   ___________________________   ___________________________
   (Spouse / Responsible Party)   Relationship   DATE

____________________________________________________________________
Interviewer
LETTER OF SUPPORT / ASSISTANCE

PATIENT:                                                                                                                         DATE:

BIRTHDATE:                                                                            INITIAL DATE OF SERVICE:

TO BE COMPLETED BY PERSON WHO IS PROVIDING SUPPORT TO THE PATIENT. DOES NOT INCLUDE A SPOUSE LIVING WITH YOU.

I certify that the information listed below is true and correct. I fully understand that giving false information or the failure to give complete information requested can constitute grounds for fraud and Meridian Health may take any legal action appropriate. I further understand that I will personally held responsible if information is falsified, incomplete, or in any way misleading.

Check below whatever applies:

☐ The above named person lives with me, and has since (Date): _______________________________

☐ The above named person was a N.J. resident at the time of the service, has no residency in any other state or country and intends to remain in the state.

☐ The above named person is not covered by any type of medical insurance including Medicaid or Medicare.

☐ The above named person is unemployed at this time and has been for at least one month prior to the date of service indicated above.

☐ The above named person does not receive unemployment benefits or any other type of benefits, such as Disability, SSI, Welfare, etc.

☐ I am providing Food and Shelter for the above named person.

☐ I am providing Cash in the amount of $__________________per month, to the above name person.

☐ The above named person does not live with me but I provide support in the form of:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Signature                                                                                           Your relationship to the above named

Address:      ______________________________________________________________________

________________________________________________________________________________

Phone Number:  __________________________________________________________________________