HMH CARRIER CLINIC, INC.

FINANCIAL ASSISTANCE PROGRAM (FAP)

PFS USE ONLY
DATE APPLICATION RECEIVED

Proof of identification, residency, most recent federal tax returns, income and assets must accompany this application.
Please send copies of all requested documents, do not send original documents as they will not be returned.
For help, assistance or questions please call Patient Financial Services 908-281-1522

I. Personal Information

HOSPT ACCT # _____

Patient name (last, first, middle initial) _____ Marital Status _____ Social Security # _____

(ADDRESS NUMBER AND STREET) _____ OWN _____ RENT HOW LONG _____

(CITY,STATE, ZIP CODE) _____ (COUNTY) _____

HOME PHONE _____ DAYTIME PHONE _____

Name of person completing application _____ Relationship to patient _____ Telephone number _____

Name of guarantor (if other than Patient) _____ Relationship to patient _____ Telephone number _____

II. Insurance Information

Name of Insurance _____ Subscriber Name _____ Relationship to pt _____

If no insurance - Have you applied for health coverage through the Marketplace? YES _____ NO ____
Are you exempt from applying for coverage through the Marketplace YES _____ NO ____

Have your applied for Medical Assistance in the past 6 months? YES _____ NO ____
If YES, please enclose a copy of the Letter of Denial or Proof of Eligibility. YES _____ NO ____

If NO, please contact your local Board of Social Services office for guidance how to apply for benefits.

III. Household information (List all people who live in your household)

HOUSEHOLD SIZE _____

Name of Household Member including patient	Relationship to Patient	Occupation
	PATIENT	

Continue Household Member	Relationship to Patient	Occupation

IV. Sources of Household Income/Assets (includes a relative by blood, marriage or adoption)

Household Income:

(Please identify if monthly (M) or annual income (A))		PATIENT	REMAINING HOUSEHOLD
Salary/Wages Before Deductions	M A	$	$
Self employed (verified by independent source)	M A	$	$
Social Security Benefits	M A	$	$
Alimony/Child Support	M A	$	$
other Monetary Support	M A	$	$
Unemployment & Workman's Compensation	M A	$	$
Veterans Benefits	M A	$	$
Pension Payments	M A	$	$
Insurance and Annuity payments	M A	$	$
Dividends/Interest	M A	$	$
Rental Income	M A	$	$
TOTAL			

Household Assets:

OTHER ASSETS	PATIENT	REMAINING HOUSEHOLD
Savings	$	$
Checking	$	$
Certificate of Deposit (CD)	$	$
Money Market Accounts	$	$
Savings Bonds	$	$
Stocks	$	$
Bonds	$	$
IRA's	$	$
401(K)	$	$
403(b)s	$	$
Other	$	$
TOTAL		

V. Certification by Applicant

I certify that the above information regarding my family size, income and assets is true and correct.

I understand that willful misrepresentation of information submitted will make me liable for all hospital charges.

I understand that it is my responsibility to inform the hospital of any change in status in regard to my income or assets .

Patient Signature DATE

Preparer Signature /Relationship to Patient) Date

FORM #991 (JAN,2019)