AtlantiCare
REGIONAL MEDICAL CENTER

FINANCIAL APPLICATION

PROOF OF INCOME MUST ACCOMPANY THIS APPLICATION. (2 pay stubs)

SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTS AS THEY WILL NOT BERETURNED.

SECTION I - Personal Information

1. PATIENT NAME: (Last) (First) (MI)	2. SOCIAL SECURITY NUMBER: (If applicable)
3. DATE OF APPLICATION:	4. ACCOUNT NUMBERS OR SPECIFIC DATE OF SERVICE THIS APPLICATION COVERS:
5. STREET ADDRESS:	6. TELEPHONE NUMBER:
7. CITY, STATE, ZIP CODE:	8. *FAMILY SIZE:

*Family size includes self, spouse, and any minor children. A pregnant woman is counted as two family members.

9. U.S. CITIZENSHIP? YES or NO

10. NAME OF GUARANTOR (if other than patient):

SECTION II - Income Criteria

11. SALARY/WAGES BEFORE DEDUCTIONS $_____

Include copies of two pay stubs to support salary/wages.

SIGNATURE OF PATIENT OR GUARANTOR:

DATE:

MAIL APPLICATION AND COPIES OF PAY STUBS TO: ATLANTICARE BUSINESS OFFICE CUSTOMER SERVICE
65 JIMMIE LEEDS RD.
POMONA, NJ 08240

For office use only:	RECEIVED DATE:	REVIEW DATE:
ANNUAL INCOME: $		FEDERAL POVERTY LEVEL: %
APPROVED (circle): YES NO (Check all reasons that apply)	**REASONS FOR DENIAL:** ____Patient Liability Less Than The Amount Of Discounted Charge Calculation ____Patient Over Income OTHER:_____	
PROGRAMS REFERRED TO FOR ADDITIONAL CONSIDERATION (circle all that apply): Charity Care Medicaid Other(please explain):_____		
Approved by: Print Name: Signature:		Date of Approval:
Applicant notified on (date):	Personnel who notified applicant:	
ACCOUNTS TO BE ADJUSTED (Use back of form for additional accounts and indicate to turn application over): ACCOUNT #: AMOUNT $:	ACCOUNT #: AMOUNT $:	ACCOUNT #: AMOUNT $:

9/16/15-sjg