ALLIANCE
COMMUNITY HEALTHCARE, INC.

ATTACHMENT E

UNINSURED CARE APPLICATION

PATIENT INFORMATION

Name:_____
Address: _____
_____
Telephone: (___)_____
Linked Patient Chart # _____

Date of Application:_____/_____/_____ Birth Date:_____/_____/_____ Family Size: _____
(include immediate family members in household, spouse, parents, guardians, Children under 21)

Was the patient born in the US? ( ) yes ( ) no
If no, date of arrival in the U.S._____/_____/_____

MARITAL STATUS
_____ single
_____ married
_____ separated
_____ divorced
_____widowed

PATIENT ID (maintain copy)
____ driver license
____ _____
____ passport
____ military identification card
_ employee identification card
other

HEALTH INSURANCE STATUS (maintain copy)
Does patient have any of the following?_____Private Ins._____Medicaid_____NJ FamilyCare
_____Welfare _____SSI _____Medicare

If yes, effective date:_____/_____/_____

SCREENING FOR MEDICAL ASSISTANCE
***If patient is uninsured, was he/she referred for medical assistance?*_____yes _____no**
If yes, date of referral:_____/_____/_____

INCOME INFORMATION (maintain copy)
Is patient/guardian(s) currently employed? _____yes _____no
Total family income per month: $_____ per year: $_____
Proof of family income (check all that apply):

_____ paycheck _____ child support payment _____ disability benefit

_____ unemployment benefits _____ foster care benefit _____other
_____ income tax return _____ employer statement

Family members in household	**Relationship to applicant**
_____	_____
_____	_____
_____	_____

I certify that the above information is true and correct. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to punishment.

_____ _____
Patient (Parent/Guardian) Signature Date

========== HEALTH CENTER USE ONLY ==========
Center employee reviewing above information:

_____ _____
Signature Date

ATTACHMENT F

MEDICAL ASSISTANCE REFERRAL FORM

Patient Name:_____ **Patient ID#:** _____

SECTION I

Annual Family Income $_____ Divided by 12 (Monthly Family Income) $_____

Birth Date of Patient:_____/_____/_____ Age of Patient: _____

SECTION II *(circle the box that applies; if no box applies go to **SECTION III**)*

See Slide Attachment

SECTION III

The patient will not be referred for Medicaid/NJ FamilyCare/ACA or other governmental medical assistance programs because (check all that apply):

_____monthly family income is too high
_____patient unable to document alien status
_____unqualified alien (entered after 8/96)
_____patient (child) is too old
_____not NJ resident
_____other _____

SECTION IV (*this section to be completed by the patient)*

Health Center staff has informed me about Medicaid/NJ FamilyCare/other governmental medical assistance programs. *(Check only one below)*

_____I understand that I/my dependent may qualify for one of the above referenced programs. I accept the referral, and agree to apply for medical assistance.

_____I understand that I/my dependent does not qualify for any of the above referenced programs, Consequently I/my dependent is not being referred for medical assistance.

_____I understand that I/my dependent may qualify for one of the above referenced programs; however, I am not interested in applying for any of the medical assistance programs at this time and **understand I will be responsible for all fees related to my care and/or that of my dependent(s)**.

_____ _____/_____/_____
Signature of Patient/Guardian Date

_____ _____/_____/_____
Signature of Health Center Staff Date

ATTACHMENT G

Self-Pay/Non-Paying Patient Attestation Form

Please check the box below that best fits your situation:

[ ] I am currently living with friends, relatives or others that are providing me with food, shelter and other necessities; I do not have funds available to pay for medical/dental services. **(Letter of Support Required)**

[ ] I do not have a place to stay and am provided with food from the local social service agencies; I do not have funds available to pay for medical/dental services.

[ ] I am a resident at the temporary shelter (below) and they are providing me with food and shelter; I do not have funds available to pay for medical/dental services. **(Letter of Support Required)**

Name of Shelter

By signing this form, I am requesting the State of New Jersey, Department of Health, to provide a minimal level of funding for any visits while I remain in my current status. Also, I am declaring that the information provided above and attested to, by my signing below, is a true accounting of my present status. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to punishment.

_____ _____

Name (Printed) **Date**

_____ _____

Name (Signed) **Phone Number**

Address of current living quarters