



Hackensack  
Meridian Health

## Hackensack Meridian Health Compassionate Care II/III Financial Assistance Application

To submit a completed application:

Email to: [FCdocuments@hmhn.org](mailto:FCdocuments@hmhn.org) Fax#: 551-996-3423

By mail: 60 Second St, 4th Fl, Hackensack, NJ 07601 Attn: Financial Counseling Dept

### Personal Information:

Account #: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name (Last, First) \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Preferred #): \_\_\_\_\_ Email Address: \_\_\_\_\_

Guarantor/Responsible Party (if different from patient)

Guarantor Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone # (if different from above) \_\_\_\_\_

### Financial Information:

Household Size: \_\_\_\_\_ (all adults and children under 21 living in the household)

Total Annual Gross Household Income: \_\_\_\_\_ Source of Income: \_\_\_\_\_  
*(ie. employment, social security, self employment, etc.)*

This program is intended for those who do not qualify for Medicaid or Charity Care and whose income falls below 600% of the Federal Poverty Level (FPL). To be considered for the program, please provide your most recent tax return or other proof of income, along with this application.

Would you like information about an interest free payment plan? \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_ I attest that all the information I provided above is correct and accurate.

Signature of Patient or Responsible party \_\_\_\_\_ Date: \_\_\_\_\_

HMH Financial Assistance Rep: \_\_\_\_\_ Date: \_\_\_\_\_