Atlantic Health System

If married, to be completed by spouse

☐ ___MORRISTOWN MEDICAL CENTER
☐ ____ OVERLOOK MEDICAL CENTER
☐ ____NEWTON MEDICAL CENTER
_____CHILTON MEDICAL CENTER

C E R T I F I C A T I O N S

___ A. I have (#) _____ minor children.

___ B. I am: Single, Married, Divorced, Widow, Separated and have no Financial ties with my spouse.

___ C. I receive no child support/alimony from my former spouse/other.

Signed: _____

___ D. I certify that I have had no income from: ____/____/_____ to ____/____/_____.

Signed: _____

___ E. At the time of service I was ____ unemployed or ____ employed by: _____

Date of Hire: ____/____/_____ I was receiving $ _____ Weekly, Bi Weekly, Monthly, Yearly.

Other income received from _____ $ _____ Weekly, Bi Weekly, Monthly, Yearly.

___ F. I certify that I have no assets.

Signed: _____

___ G. I attest that I am homeless and have been since ____/____/_____. I do/ I do not occasionally stay at a local shelter. I do/ I do not have identification.
Name/Address of Shelter: _____

Signed: _____

___ H. I attest that I have not filed any income tax return for the year _____ because _____.

___ I. I certify that I have no health coverage.

Signed: _____

___ J. I have resided at _____

By myself / with _____

___ K. I have been a resident of the State of New Jersey since _____. I have no residency in any other state or country and have every intention on continuing my residency in New Jersey.

Signed: _____

___L. I am not a resident of the State of New Jersey. I was admitted into the hospital under emergency circumstances.

Signed: _____

___ M. I am making this Affidavit in order to apply for Charity Care.

I understand that the information which I have submitted is subject to verification by Atlantic Health System and the Federal or State Governments. Willful misrepresentation of these facts will negate the hospitals right to receive reimbursement for any charges not covered by a third party insurance carrier. If so requested by Atlantic Health System I will apply for government or other medical assistance for payment of the hospital bill if I qualify for assistance. I certified that the information with regard to my income, family size and assets is true and accurate to the best of my knowledge.

Signed: _____ Date: _____

Witness: _____ Date:_____