BORINQUEN MEDICAL CENTERS

Patient's Name/Non Pasyan: _____ MR#: _____

Undeclared Income Verification Form

I _____, understand that I am receiving this form because I did not provide proof of income and family size today. As a result, I will be placed in Slide B for 30 days. This means, I will be financially responsible for 25% of my charges. I understand that failure to provide Borinquen Medical Centers with proof of income and family size within the 30-day period will result in me being placed on Slide E and I will be financially responsible for 100% of my charges. I acknowledge:

1. I have been given the list of documents required to determine my eligibility.
2. I have been offered an appointment with an Eligibility Specialist to determine my insurance eligibility.

By signing below, I understand and agree to the terms above.

Signature: _____ Date: _____

Staff Witness: _____ Date: _____

Fòm Vérifikasyon Kob ki Pa Déklaré

Mwen _____, konprann ké mwen ap résévwa fòm sa a paské mwen pa t 'bay prèv révni ak gwosè fanmi jodi a. Kòm yon rezilta, yo pral méte mwen nan Slide B pou 30 jou. Sa vlé di, mwen pral finansyèman responsab 25% nan chaj mwen yo. Mwen konprann ké nan peryòd la 30-jou sa mwen pa bay Borinquen Medical Center prèv révni ak gwosè fanmi'm sa pral lakòz ké yo méte'm nan Slide E, épi mwen pral finansyèman responsab 100% chaj mwen an.
Mwen rékonèt:

1. Yo ban mwen lis dokiman ki nésésè pou détèminé kalifikasyon mwen an.
2. Yo ofri m 'yon randevou ak yon Espesyalis Kalifikasyon pou détèminé kalifikasyon asirans mwen an.

Lè mwen siyien anba a Mwen konprann épi mwen dakò ak tout komdisyon yo sot sité anwo yo.

Siyati: _____ Dat: _____

Anplwayé Témwen: _____ Dat: _____