Cooper University Health Care

Reason to Know

Patient Name: _____ **Account Number:** _____

Date of Service: _____

I,_____, am _____of the patient.
(Signer's Name) (Relation to Patient)

I am completing this New Jersey Hospital Care Payment Assistant Program application on behalf of the above named individual, who is not able to complete the application because:

_____
(Brief Explanation)

_____

_____

_____ _____
Signature **Phone**

_____ _____
Print Name **Date**