New Jersey Hospital Care Payment Assistance Program

APPLICATION FOR PARTICIPATION

PROOF OF IDENTIFICATION, PROOF OF INCOME, AND PROOF OF ASSETS MUST ACCOMPANY THIS APPLICATION.
SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTS, AS THEY WILL NOT BE RETURNED.

SECTION I – Personal Information

1. PATIENT NAME __________ __________ ____ (Last) (First) (MI)		SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
3. DATE OF APPLICATION _____/_____/_____ Month Day Year	4. INITIAL DATE OF SERVICE _____/_____/_____ Month Day Year	5. REQUESTED DATE OF SERVICE _____/_____/_____ Month Day Year
6. STREET ADDRESS OF PATIENT		7. TELEPHONE NUMBER (__ __ __) __ __ __ - __ __ __ __
8. CITY, STATE, ZIP CODE		9. FAMILY SIZE *
10. U.S.CITIZENSHIP ☐ Yes ☐ No ☐ Pending Application	11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ ☐ Yes ☐ No	
12. NAME OF GUARANTOR (If other than patient)		

SECTION II – Assets Criteria

13. Individual Assets: ____________________

14. Family Assets: ____________________

15. Assets Include:

A. Cash ____________________

B. Savings Accounts ____________________

C. Checking Accounts ____________________

D. Certificates of Deposit / I.R.A. ____________________

E. Equity in Real Estate (other than primary residence) ____________________

F. Other Assets (Treasury Bills, negotiable paper, Corporate stocks and bonds) ____________________

G. Total ____________________

* Family size includes self, spouse, and any minor children. A pregnant woman is counted as two family members.

APPLICATION FOR PARTICIPATION (Continued)

SECTION III – Income Criteria

When determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult; parent's income and assets must be used for a minor child. *Proof of income must accompany this application.*

Income is based on the calculation of either twelve months, three months or one month of income prior to the date of service.

Patient / Family Gross Income equals the lesser of the following:

Last 12 Months		Last 3 Months X4		Last 1 Month X12
	or		or	

16. SOURCES OF INCOME

	Amount	Weekly	Monthly	Yearly
A. Salary / Wages Before Deductions	______	☐	☐	☐
B. Public Assistance	______	☐	☐	☐
C. Social Security Benefits	______	☐	☐	☐
D. Unemployment & Workmen's Compensation	______	☐	☐	☐
E. Veteran's Benefits	______	☐	☐	☐
F. Alimony / Child Support	______	☐	☐	☐
G. Their Monetary Support	______	☐	☐	☐
H. Pension Payments	______	☐	☐	☐
I. Insurance or Annuity Payments	______	☐	☐	☐
J. Dividends / Interest	______	☐	☐	☐
K. Rental Income	______	☐	☐	☐
L. Net Business income (self employed/ verified by independent source)	______	☐	☐	☐
M. Other (strike benefits, training stipends, military family allotment, income from estates and trusts)	______	☐	☐	☐
N. Total	______	☐	☐	☐

SECTION IV – Certification By Applicant

I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

If so requested by the health care facility, I will apply for governmental or private medical assistance for payment of the hospital bill.

I certify that the above information regarding my family size, income, and assets is true and correct.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

17. Signature of Patient or Guarantor	18. Date