THE REQUESTED INFORMATION BELOW MUST BE PROVIDED AT THE TIME OF YOUR INTERVIEW WITH A FINANCIAL COUNSELOR.
******ADDITIONAL INFORMATION MAY BE REQUESTED AFTER THE APPLICATION IS REVIEWED. ******

******PLEASE NOTE THAT ANY AND ALL INFORMATION BEING PRINTED FROM THE INTERNET, MUST BE VERIFIED BY A SIGNATURE AND STAMP FROM THAT COMPANY.******

PROPER IDENTIFICATION (SUPPLY ONE OF THE FOLLOWING FOR EACH FAMILY MEMBER) *** If you are a full time college student 21 yrs or younger you must provide all documents for both parents as well. They will be included in your family size as well as any sibling who is a full time student 21 yrs or younger ***

1. Driver's License
2. Social Security Card
3. Valid Passport
4. Birth Certificate

PROOF OF NEW JERSEY RESIDENCY: (FOR THE MONTH OF YOUR REQUESTED SERVICE). You must supply one of the below required documents.

1. Utility Bill
2. Copy of Lease or Deed
3. Driver's License
4. Letter from individual stating that you live with him/her

INCOME:
Actual gross income for the month immediately preceding the date of service or three month's income immediately preceding service:

a) Pay stubs, unemployment stubs, disability, child support.
b) A letter from employer(s) on company letterhead (INCLUDING Name, Address and Telephone number) – Letter must state the Gross Income, also needs to state if covered by health insurance.
c) Copy of social security and/or pension award letter.
d) If not employed and have no income, must supply a letter from person supporting you.
e) If you receive financial aid for schooling you must supply the financial aid award letter for your last 2 semesters immediately preceding your date of service.

LIQUID ASSETS:
You must provide copies of any checking and savings accounts, IRA's, CD's, stocks and/or bonds, or any other account which can be readily converted into cash. All account statements must be valid for the date of service in question.

MEDICAID ELIGIBILITY:
If you are a under the age of 18, over the age of 65, Blind or Disabled or pregnant- You must show proof that you were screened for eligible Medicaid programs.

COPY OF ALL PAGES YOUR COMPLETED TAXES AND W2 FOR THE PRIOR YEAR

COPIES OF ANY AND ALL INSURANCE CARDS FOR EACH FAMILY MEMBER

New Jersey Hospital Care Assistant 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) (M)

2. 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.

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(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	or	Last 3 Months x 4	or	Last 1 Month x 12

16. SOURCES OF INCOME:		WEEKLY	MONTHLY	YEARLY
A. Cash		☐	☐	☐
B. Public Assistance		☐	☐	☐
C. Social Security Benefits		☐	☐	☐
D. Unemployment & Workmen's Compensation		☐	☐	☐
E. Veteran's Benefit		☐	☐	☐
F. Alimony/Child Support		☐	☐	☐
G. Other 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

Date:_____

To Whom It May Concern:

This is to state that I_____ do **NOT** have the following (please check off what you do **NOT** have):

- ❑ _____ 1040 Income Tax (Federal)
  Year
- ❑ Did Not File
- ❑ Do not work, collect unemployment, disability or receive financial assistance.
- ❑ Checking Account
- ❑ Savings Account
- ❑ CD'S/STOCKS/ I.R.A. PLANS/ 401K
- ❑ Medical/Dental/No Fault Insurance

_____
Signature

Additional Comments:_____

_____

_____

_____

Date:_____

To Whom It May Concern:

This is to state that I_____do **NOT** have the following (please check off what you do **NOT** have):

- ❑ _____ 1040 Income Tax (Federal)
  Year
- ❑ Did Not File
- ❑ Do not work, collect unemployment, disability or receive financial assistance.
- ❑ Checking Account
- ❑ Savings Account
- ❑ CD'S/STOCKS/ I.R.A. PLANS/ 401K
- ❑ Medical/Dental/No Fault Insurance

_____
Signature

Additional Comments:_____

_____

_____

_____

To Whom It May Concern:

I, the undersigned, _____ (relation to patient)

_____, provide the necessary room, board and other life essentials for

_____ at my residence,

_____, and have been doing so from

_____ to _____.

I am not responsible or able to pay for any hospital or other medical expenses for him/her.

_____ _____

Signature Date

Telephone #: (____) _____

Date: _____

I_____state that I am not married to my son's/daughter's/children's father and receive no financial support from him although he provides us with food and shelter.

_____

Signature

I_____state that I am not married to my son's/daughter's/children's father and receive no financial support for him/her/them.

_____

Signature

I_____state that I am not married to my son's/daughter's/children's father but I do receive financial support for him/her/them.

_____

Signature

Date of initial separation: _____

Legal residence of applicant: _____

_____

Legal residence of spouse: _____

_____

I, _____, certify and attest to the truthfulness of the following:

1. That my spouse and I are separated and no longer reside together.
2. That I have no access to the funds of my spouse.
3. That I receive no support or monies from my spouse.
4. That my spouse and I have no financial ties.
5. That my spouse and I do not mingle or join our funds in any way, including the filing of joint federal or state income tax returns.

Signature: _____ Date: _____

APPLICATION FOR FINANCIAL ASSISTANCE

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 hereby certify that the information provided for purpose of creating a financial assistance/Charity Care application is correct to the best of my knowledge.

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

_____ _____

APPLICANT SIGNATURE DATE

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

PROVIDER NAME: