NEW JERSEY HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM

FACT SHEET

WHAT IS THE HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM?

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care, which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.

WHO IS ELIGIBLE FOR HOSPITAL ASSISTANCE?

Hospital care payment assistance is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: ***and***
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid): ***and***
3. Meet ***both*** the income and assets eligibility criteria.

WHAT DO I NEED TO PROVIDE TO COMPLETE AN APPLICATION?

There are four (4) types of documents patients must provide to complete the application:

1. Identification
2. Proof of Residency
3. Proof of Income (1 month, 13 weeks or 1 year prior to the date of service)
4. Proof of assets

For examples, see the details on the back of this form.

Please be advised that additional paperwork may be required to support your application.

Thank you for choosing Capital Health as your health care provider.

CHARITY CARE REQUIREMENTS

In order to apply for the Charity Care Program and determine your eligibility, you will need the following documents.

1. **Form of Identification** (i.e. Driver's License, State/County ID, S.S. Card, Birth Certificate, Passport, Visa, Alien Registration Card, Employee ID card, Student ID, or Union Membership Card).

2. **Proof of New Jersey Residency for or prior to the date of service** (i.e. Utility Bill, Phone Bill, Copy of Deed or Lease, any of the above forms of ID with the address and an effective date which compares to the application date, mail received with the applicants name and current address and an attestation that the patient resides in NJ since the date of service or a letter from the landlord, roommate or other NJ resident with whom the applicant is living stating the NJ address).

3. **Income Information prior to the Date of Service** (i.e. paystubs, employer letter, Benefit Statement for Unemployment, Disability or Social Security, Letter from Employer on Company letterhead stating exact income for applicable time period, Income Tax returns or a signed statement of no income and a letter of support).

4. **Asset Information as of the Date of Service** (i.e. Bank Statement for Checking or Savings Account, Other Bank Accounts, IRAs, 401ks, CDs or other Stocks, Bonds or Negotiable Paper).

5. **Other** _____

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Please be advised that additional paperwork may be required to support your application. If you would like to schedule an appointment or if you have any questions, please call:

Regional Medical Center (Trenton) 609.394.6128
Capital Health Medical Center (Hopewell) 609.303.4117
Family Medicine Center (Clinic –Trenton) 609.394.4435