New Jersey Hospital Assistance Program

APPLICATION FOR PARTICIPATION

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

Medical Record # **SECTION I – Personal Information** **Account #**

1. Patient Name

_____ _____ _____
Last First Initial

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. Current Address of Patient

7. Telephone Number

(__ __ __) __ __ __- __ __ __ __

8. State, Zip Code

9. Family Size*

10. Citizenship

☐ Yes ☐ No ☐ Pending Application

11. Proof of New Jersey Residency

☐ Yes ☐ No

12. Name of Guarantor (if different from patient)

Health Insurance Coverage?

☐ Yes ☐ No

SECTION II – Assets Criteria

(Please list the exact dollar amount of the below items as of the date of service in box # 4 above)

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) _____

FAMILY MEMBERS NAME: (should equal the family size)

	LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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

SECTION III – Income Criteria

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

Income is based on the calculation of twelve months, three months, one month or one week of income prior to the date of service (Box #4.)

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

LAST 12 MONTHS		LAST 3 MONTHS X 4		LAST 1 MONTH X 12		LAST 1 WEEK X52
	or		or		or	

16. SOURCE OF INCOME:

		WEEKLY	MONTHLY	YEARLY
A. Salary / Wages before Deductions		☐	☐	☐
B. Public Assistance		☐	☐	☐
C. Social Security Benefits		☐	☐	☐
D. Unemployment & Workman's Compensation		☐	☐	☐
E. Veteran's Benefits		☐	☐	☐
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 sources		☐	☐	☐
M. Other (strike benefits, training stipends, Military family allotment, income from estates And trusts)		☐	☐	☐
N. TOTAL INCOME		☐	☐	☐

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 Local or State Government. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

As 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 changes in status in regards to my income or assets.

17. Signature of Patient or Guarantor	18. Date

AFFIDAVIT OF FACTS

ACCT# _____ M/R# _____

Patient: _____ Date of Service: _____

Guarantor: _____ Relation to Patient: _____

1. At the time of service, I resided at: _____
Address

_____
City **State** **Zip**

2. At the time of Service, I was ☐ Unemployed ☐ Collecting ☐ Retired ☐ Employed by:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

I was earning/collecting: $ _____ per _____

Other income received by myself/spouse includes: $ _____ per _____

Source of additional income: _____

☐ At the time of Service I (Patient or Spouse) had no income. I was supported by:

_____ Relation: _____

Address: _____

3. I am: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

I have _____ (#) minor child(ren) living with me. Child Support received? ☐ Yes ☐ No

☐ I / We had no insurance at the time of service. ☐ I / We had no insurance coverage or had limited coverage only

4. On the first date of service I/we had liquid assets in the amount of: $_____.

Bank: _____.

☐ At the time of Service, I/we had no liquid assets what-so-ever.

I/We are making this Affidavit in order to apply for Charity Care. I'm/We're aware that this assistance is only available for medically necessary hospital care and that costs incurred for physician services, anesthesiology services, radiology interpretation and outpatient therapy and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.

By signing this affidavit, I am certifying that I am who I claim to be. I/ We are aware, if any of the foregoing statements are false, I/ We are subject to punishment.

Signed: _____ ***Date:*** _____

Signed: _____ ***Date:*** _____

Hospital Care Assistance (Charity Care) Coverage

I have been informed that the New Jersey Hospital Care Assistance Program (NJHCAP) covers Capital Health hospital based billing only. I understand that I may be responsible for private physician fees associated with my care.

During my application I was informed that Emergency Department physicians and other physicians such as; Radiologist, Pathologists, Cardiologists and Anesthesiologists, who may have rendered services during my visit(s), are not required to honor the NJHCAP discount.

I further understand that I will need to communicate directly with the providers of service

or their billing service, regarding any outstanding balances that were not billed directly by Capital Health and are not covered by the New Jersey Hospital Care Assistance Program.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINT NAME

AFFIDAVIT OF NO MEDICAID APPLICATION

Patient: _____

Date of Service: _____

Account Number: _____

Date: _____

To Whom It May Concern,

I hereby attest to the following:

_____ I understand I may be eligible for Medicaid but I do not wish to apply at this time.

_____ I have no intention of applying for Medicaid now or in the near future for the above stay.

_____ I applied for Medicaid but I was found ineligible due to the following reason:

_____

_____ I cannot apply for Medicaid because of the following reason:

_____

_____ I was found eligible for Medicaid as of this date: _____

_____I was found eligible for Medicaid but the above date of service is not covered.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing Statements made by me are willfully false, I will be subject to penalties or punishment according to the laws of New Jersey.

_____ _____

SIGNATURE **WITNESS SIGNATURE**

_____ _____

PRINT NAME **PRINT NAME**

AFFIDAVIT OF SEPARATION

To Whom It May Concern:

I hereby state that I have been separated from my spouse: _____

since _____/_____/_____.

We do not have any financial ties what so ever. We do not own any property or other investments jointly, and we do not file taxes together.

I do not receive ant alimony, child support or other financial assistance from him/her.

_____ _____/_____/_____

Signature Date

ATTESTATION FOR HOMELESS

Date: _____/_____/_____

Acct #: _____

Patient: _____

I _____, attest that I am homeless and have been

since _____. I have no income, no health insurance, no assets,

no identification or proof of address.

_____ _____/_____/_____

Signature **Date**

_____ _____/_____/_____

Witness **Date**

STATEMENT IN SUPPORT OF
CHARITY CARE APPLICATION

DATE: _____/_____/_____

PATIENT: _____

ACCOUNT# _____

To Whom It May Concern:

_____

_____

_____

_____

_____ _____

Signature ***Spouse/Supporter/Other***

_____ _____

Print Name ***Print Name***

_____ _____/_____/_____

Witnessed By ***Date***