Jefferson Health

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)	13. IS PT OVER 65 YEARS OLD? ☐ Yes ☐ No ☐ CWF Included

14. IS PT COVERED BY INSURANCE? ☐ Yes ☐ **No**

SECTION II – Assets Criteria

15. Individual Assets: _____

16. Family Assets: _____

17. 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.

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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		Last 1 Month X13

18. SOURCES OF INCOME

		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.

19. Signature of Patient or Guarantor 20. Date

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Patient Primary Attestation

Patient Name: _____ Account Number: _____

Date of Service**:** _____

Please Initial

____ **I and/or my spouse attest I/we have no income and have had no income since ___/___/___ to ___/___/___**

____ **I and/or my spouse attest I have no assets as listed on the charity care application.**

____ **I and/or my spouse attest I am homeless and have been homeless since___/___/___**

____ **I attest I have no Medical Insurance at the time of my admission to the Hospital.**

____ **I attest that my name is _____. I cannot provide proof of identification because: _____**

(State Reason)

_____

____ **I and/or my spouse attest I/we have income. Our gross/cash income is $_____ and we get paid on a _____ basis.**

Frequency

____ **I and/or my spouse attest I have assets on the date of service above for the amount of $_____.**

____ **I and/or my spouse attest I am a resident of New Jersey and intend to keep New Jersey as my residence.**

____ **I attest that I have not made and that I do not intend to make a claim against any third party in which I can seek payment, in whole or in part, for the medical services to which this application relates (including, without limitation, claims for no fault, workers compensation, homeowners, underinsured or uninsured motorist insurance benefits and tort claims). I understand and agree that, if any such claim is made, Jefferson Health may retract its charity care and seek payment of all charges from me. I also agree to notify Jefferson Health when a claim is filed.**

_____

Patient Signature

_____

Printed Name

_____

Date

Attestation of Exclusions from the New Jersey Hospital Assistance Program

I, _____ , have been informed that the
PATIENT NAME
New Jersey Hospital Assistance Program (NJHAP) is for Jefferson Health billing only.

I understand, that I may be responsible for private physician fees associated with my care. Emergency Department Physicians, physicians who read and interpret tests, such as Radiologists, Pathologists, and Cardiologists, Anesthesiologists, and all other treating physicians are not required to honor the NJHAP discount.

I further understand, that I will need to make separate payment arrangements for all physicians included in my care or interpretation of services provided directly with the physician's office or billing company.

_____ _____
PATIENT SIGNATURE **DATE**