New Jersey Hospital Care 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						**2. SOCIAL SECURITY NUMBER**			
(Last Name)		(First Name)		(M.I.)					
3. DATE OF APPLICATION			**4. INITIAL DATE OF SERVICE**			**5. REQUESTED DATE OF SERVICE**			
Month	Day	Year	Month	Day	Year	Month	Day	Year	
6. STREET ADDRESS OF PATIENT						**7. TELEPHONE NUMBER**			
8. CITY, STATE & ZIP CODE						**9. FAMILY SIZE***			
						#	Name		D.O.B.
10. U.S. CITIZENSHIP						**11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF N.J.**			
	YES		**NO**		**PENDING APPLICATION**		**YES**		**NO**
12. NAME OF GUARANTOR (if other than patient)/Other									

Section II—ASSETS CRITERIA

13. Individual Assets:	
14. Family Assets:	
15. Assets Included:	
A. Cash	
B. Savings Accounts	
C. Checking Accounts	
D. Certificates of Deposit/I.R.A.s	
E. Equity in Real Estate (other than primary residence)	
F. Other Assets (Treasury Bills, negotiable paper, corporate stocks and bonds)	
G. Total	
TOTAL	

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

	HCS		**CLINSTAR**		**EXCEL**

When determining eligibility for hospital care assistance, a spouse's income and assets <u>MUST</u> be used for an adult; parent's(s') income and assets <u>MUST</u> be used

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 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. Salary/Wages before deductions			
B. Public Assistance			
C. Social Security Benefits			
D. Unemployment & Worker'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 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 that I submit is subject to verification by the appropriate health care facility and the Federal and/or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to criminal and civil penalties.

If so requested by the health care facility, I will apply for governmental or private medical insurance 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 regarding my income or assets.

17. SIGNATURE OF PATIENT OR GUARANTOR	18. DATE