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

SECTION I- Personal Information			
Patient Name			Social Security Number
Last name	First name	M.I.	___-___-___
Date of Service		Date of Application	
Identification	Proof of Residency (as of)	Family Size*	

SECTION II- Income Criteria	PA/ MO	SP/FA	Weekly	Biweekly	Monthly
A. Salary/Wages Before Deductions			[ ]	[ ]	[ ]
B. Public Assistance			[ ]	[ ]	[ ]
C. Social Security Benefits			[ ]	[ ]	[ ]
D. Unemployment/ Workman's Compensation			[ ]	[ ]	[ ]
E. Veteran's Benefits			[ ]	[ ]	[ ]
F. Pension Payments			[ ]	[ ]	[ ]
G. Alimony/ Child Support			[ ]	[ ]	[ ]
H. Other Monetary Support			[ ]	[ ]	[ ]
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. No Income _____					
O. Provision letter: _____					

*Family size includes self, spouse, and any minor children. A pregnant woman counts as two family members

APPLICATION FOR PARTICIPATION (Continued)

SECTION III- Asset Criteria

	PA/ MO	SP/FA
A. Checking Accounts		
B. Savings Accounts		
C. Certificates of Deposit/ I.R.A.		
D. Equity in Real Estate (other than primary residence)		
E. Cash		
F. Other Assets (Treasury Bills, negotiable paper, Corporate stocks and bonds)		
G. No Assets		

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 the 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 to 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.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness Date

Patient Attestation Statement

Patient Name: _____ **Patient Number:** _____

1. **I attest that I and/ or my spouse have no income and have had no income**

   From: ___/___/___ **To:** ___/___/___ **(PA)**_____
   (Patient/ responsible party)

   Notes: _____

   _____

   _____

   _____

2. **I attest that I and/ or my spouse have no liquid assets through myself/ourselves or any other party.**

   _____
   (Patient/ responsible party)

3. **I attest that I am homeless and have been homeless since** _____

   _____
   (Patient/ responsible party)

4. **I have not come to New Jersey for the sole purpose of receiving medical treatment. I have been residing in New Jersey before and at the time of service. I have no other residency in any other state or country and have the intent to remain here.**

   _____
   (Patient/ responsible party)

5. **I attest that I have no health insurance coverage through myself or any member of my family unit that would pay for this admission.**

   _____ ___/___/___
   (Patient/ responsible party)

   _____ ___/___/___
   Witness **(date)**

Deborah Heart and Lung Center
Authorization for Release of Information

Address: _____

_____

_____

_____

Social Security Number: _____

I do hereby authorize and request the disclosure to Deborah Heart and Lung Center any information that may be desired concerning my residence, citizenship, employment, income and assets from my financial institution. It is understood that the information obtained will only be used for purposes directly related to my eligibility for Charity Care, New Jersey Medicaid, Pharmaceutical discounts for DHLC and Life Vest approval.

_____ _____

Date Signature of Patient or Representative

_____ _____

Date Signature of Witness

CHARITY CARE CHECKLIST

PATIENT NAME _____

PATIENT NUMBER _____ ADMISSION DATE ___/___/____

APPLICATION

QUESTIONED PATIENT REGARDING INSURANCE COVERAGE **YES / NO**

IDENTIFICATION OBTAINED _____
SIGNATURE OBTAINED _____
DOCUMENTATION OBTAINED _____
PROOF OF RESIDENCY _____
APPLICATION COMPLETED _____

SUBMITTED TO

OUTSIDE CC AGENCY _____
OUTSTATION _____
NOT SUBMITTED _____
VERIFIED UNISYS _____

MEDICARE INFORMATION

NOT APPLICABLE _____

NOT ENROLLED – COPY OF WORKING FILE ATTACHED _____

NON-CITIZEN STATUS – COPY OF WORKING FILE AND PASSPORT ATTACHED _____
NON-CITIZEN STATUS - UNDOCUMENTED ALIEN _____

MEDICARE PART A (ONLY) non payment of part B- COPY OF WORKING FILE ATTACHED_____
Pertains to Outpatient visits only

MEDICARE PART B (ONLY) - COPY OF MEDICARE CARD ATTACHED _____
- COPY OF WORKING FILE ATTACHED _____

EXCEEDS MAX BENEFIT AMT- COPY OF EXPLANATION OF BENEFIT ATTACHED _____
- COPY OF DENIAL FROM MEDICARE ATTACHED _____

COMMENTS: _____
_____
_____
_____

PATIENT ACCESS

DATE SUBMITTED ___/___/___

ORIGINAL CC APPLICATION DATE
___/___/___

CHARITY CARE REP_____

CC EXPIRATION DATE
___/___/___

PERCENTAGE OF ELIGIBILTY _____

MEDICAID SCREENING

Name:_____ Age:_____ Acct # _____

SECTION I

Is patient

_____ Pregnant _____ Blind _____ Elderly (65+)
_____ Parent of minor children
_____ Under 21 years
_____ Possible eligibility (any checked) Go to Section II.
_____ Ineligible - (none checked). **STOP HERE.**

SECTION II

Family size _____ Monthly income _____ Assets _____
Children:

1) _____ _____ yrs _____ at home _____ not at home
2) _____ _____ yrs _____ at home _____ not at home
3) _____ _____ yrs _____ at home _____ not at home
4) _____ ____ yrs _____ at home _____ not at home
5) _____ _____ yrs _____ at home _____ not at home
_____ more on reverse side

_____ **INELIGIBLE**
_____ Income/resources exceed
_____ Child (ren) do not reside with patient permanently
_____ Not disabled for one year
_____ Patient is an illegal alien and not pregnant
_____ Has not met residency requirements (five years)

STOP HERE

_____ **POSSIBLE ELIGIBILITY**
_____ Referred to O/S personnel _____ Eligible _____ Did not apply
_____ Ineligible

_____ Not referred to O/S
Personnel

Completed By: _____ Date: _____

FINANCIAL SCREENING FORM
DEBORAH HEART AND LUNG CENTER

I) INCOME * (rel codes- PA pat., SP-spouse, FA- father, MO- mother)

	Relation	Source	Annual Amount	Documentation
A)	_____	_____	_____	_____
B)	_____	_____	_____	_____
C)	_____	_____	_____	_____
D)	_____	_____	_____	_____
E)	_____	_____	_____	_____

TOTAL INCOME: $_____

II) FAMILY SIZE (include patient, spouse and all dependents): _____

III) LIQUID ASSETS (include assets of all family members counted in II above)

	ASSET CATEGORY	VALUE	VERIFICATION
A)	CHECKING	$ _____	_____
B)	SAVINGS	$ _____	_____
C)	CERTIFICATES OF DEPOSIT	$ _____	_____
D)	STOCKS (ESTIMATED VALUE)	$ _____	_____
E)	BONDS	$ _____	_____
F)	TREASURY BILLS	$ _____	_____
G)	NEGOTIABLE PAPER	$ _____	_____
H)	OTHER (SPECIFY)	$ _____	_____
I)	REAL ESTATE	$ _____	_____
	(other than primary residence)		
		$ _____	_____

DEBORAH HEART AND LUNG CENTER

FINANCIAL SCREENING FORM WORKSHEET

Patient Name: _____

Account #: _____

Expected Admission Date: _____ Charity Care Application Date:_____

Required Data/Documentation Completion Date: _____

Final Determination Date: _____ (must not exceed 5 days from completion date)

"Deborah Heart and Lung Center confirms that the information/documentation contained herein will be considered valid for a period of one (1) year commencing on _____ for the purpose of determining eligibility under existing regulations".

Patient/family gross income equals lesser of the following:

Last 12 months: _____ Last 3 months x 4: _____ Last month x 12: _____

Determination

Family Size (including patient, spouse, all dependents:) _____

			Check One
A) Meets income guidelines for	☐ **Charity Care**	☐ **Reduced Charity Care**	☐ **None**
B) Meets individual/family asset guidelines		☐ **Yes**	☐ **No**
C) Patient eligible for medical assistance?		☐ **Yes**	☐ **No**

Total income: _____ Total assets: _____

Completed by: _____

( ) Your hospital bills will be considered as Charity Care at _____ % of the billable amount

( ) We are unable to qualify you for Charity Care because:

____ Income documentation not provided ____ Asset documentation not provided

____ Income over standard ____ Assets over standard

____ Failure of patient to pursue medical assistance