Hackensack Meridian *Health*
Palisades Medical Center

New Jersey Hospital Care Assistance Program

APPLICATION FOR PARTICIPATION

PROOFS OF IDENTIFICATION, INCOME AND ASSETS MUST ACCOMPANY THIS APPLICATION. SEND COPIES OF ALL REQUESTED DOCUMENTS TO: HackensackUMC, 100 First Street Suite 300, Hackensack, NJ 07601 Attn: Financial Assistance Department. DO NOT SEND ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.

SECTION I – Personal Information			
1. PATIENT NAME (Last) (First) (M.I.)			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. 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) (Last) (First) (M.I.)			13. IS PATIENT COVERED BY INSURANCE? Yes or No NAME OF COMPANY ADDRESS

Eligible Family Members, Including Applicant

Name	Date of Birth	SS Number	Occupation	Monthly Salary

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

SECTION II – Assets Criteria	
14. Individual Assets	
15. Family Assets	
16. Assets Include	
A. Cash	
B. Savings Accounts	
C. Checking Accounts	
D. Certificate of Deposits/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	

SECTION III – Income Criteria

When determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult; parents' 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 X 4		LAST 1 MONTH X 12
	OR		OR	

17. SOURCES OF INCOME

		WEEKLY	MONTHLY	YEARLY
A. Salary/Wages Before Deductions	_____	☐	☐	☐
B. Public Assistance	_____	☐	☐	☐
C. Social Security Benefits	_____	☐	☐	☐
D. Unemployment and Workmen'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 which I submit 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 healthcare 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.

18. SIGNATURE OF PATIENT OR GUARANTOR	19. DATE

New Jersey Hospital Care Assistance Program

DETERMINATION OF APPLICATION FOR PARTICIPATION

SECTION I – Applicant Information

1. PATIENT NAME		2. FAMILY SIZE
3. DATE OF SERVICE	4. DATE OF DETERMINIATION	5. DATE OF EXPIRATION
6. INCOME COMPUTATION ☐ 12 months ☐ 3 months ☐ 13 weeks x 4 ☐ 1 month x 12		7. TOTAL INCOME

SECTION II – Medicaid Determination

8. WAS REFERRAL MADE FOR PUBLIC ASSISTANCE

☐ Yes ☐ No Explain: _____

_____

SECTION III - Determination

☐ Your request for New Jersey Hospital Care Assistance has been approved. Your financial responsibility is _____% of the hospital bill for services beginning on _____. The hospital may provide assistance of _____% of the hospital charges for any future hospital services for a period of _____ months from the initial date of service.

☐ Your request for New Jersey Hospital Care Assistance has been denied because you do not meet the eligibility requirements. Specific reasons for ineligibility are as follows:

☐ Documentation of income not provided. *
☐ Documentation of assets not provided. **
☐ Income exceeds eligibility criteria.
☐ Assets exceed eligibility criteria.
☐ Patient referred to Medicaid
☐ Failure to provide Medicaid denial
☐ Other _____

_____

*Applicants found ineligible on the fact that specific information was not provided should direct this information to the hospital:

HACKENSACK UNIVERSITY MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM
100 First Street Suite 300
Hackensack, New Jersey 07601
Financial Assistance Department
Tel: (551)996-4343
Fax: (551)996-4333

**Applicants with assets that exceed eligibility have the option to "spend down" the excess assets toward the hospital bill. If you pay _____ toward your hospital bill, the remaining balance can be considered eligible for _____ % under the New Jersey Hospital Care Assistance Program.

NAME OF EVALUATOR	TITLE
SIGNATURE	DATE

Applicants who have questions about the program may contact the

New Jersey State Department of Health
HEALTH CARE FOR THE UNINSURED PROGRAM
CN 360, Trenton, New Jersey 08625-0360
Telephone Number 1-866-588-5696

REV. 12/21/2015