



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)		(FIRST)	(MI)		
3. DATE OF APPLICATION		4. INITIAL DATE OF SERVICE		5. REQUESTED DATE OF SERVICE	
MONTH	DAY	YEAR	MONTH	DAY	YEAR
6. STREET ADDRESS OF PATIENT			7. TELEPHONE NUMBER		
8. CITY, STATE, ZIP CODE			9. FAMILY SIZE * MARITAL STATUS		
10. U.S. CITIZEN			11. PROOF OF 3 - MONTH RESIDENCY IN THE STATE OF NJ		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING APPLICATION			<input type="checkbox"/> YES <input type="checkbox"/> NO		

12. NAME OF GUARANTOR (if other than patient)

Patient's Acct #: _____ Pt's Medical Record # _____

SECTION II - ASSETS CRITERIA

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)

G. **TOTAL**

* FAMILY SIZE INCLUDES SELF, SPOUSE, AND ANY MINOR CHILDREN. A PREGNANT WOMAN IS COUNTED AS TWO FAMILY MEMBERS.

"APPLICATION for PARTICIPATION" (Continued)

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 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
	OR	OR

16. SOURCES OF INCOME:

	WEEKLY	MONTHLY	YEARLY
A. SALARY/WAGES BEFORE DEDUCTIONS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. PUBLIC ASSISTANCE _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. SOCIAL SECURITY _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. UNEMPLOYMENT/WORKMEN'S COMPENSATION _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. VETERANS BENEFITS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. ALIMONY/CHILD SUPPORT _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. OTHER MONETARY SUPPORT _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. PENSION PAYMENTS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. INSURANCE or ANNUITY PAYMENTS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. DIVIDENDS/INTEREST _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. RENTAL INCOME _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. NET BUSINESS INCOME (SELF-EMPLOYED/VERIFIED BY INDEPENDENT SOURCE) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. OTHER (STRIKE BENEFITS, TRAINING STIPENDS, MILITARY FAMILY ALLOTMENT, INCOME FROM ESTATES AND TRUSTS) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. TOTAL _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

17. SIGNATURE OF PATIENT OR GUARANTOR

18. DATE

X