Hackensack Meridian *Health*

Charity Care/Financial Assistance Application Process

You may apply for Financial Assistance within 1 year after discharge from the hospital or receipt of outpatient care.

Charity Care is available to New Jersey residents who are uninsured, underinsured, or ineligible for State and Federal programs.

To qualify you must meet both the income and assets eligibility criteria.

Charity Care covers hospital care only. The program does not apply to physicians or other providers who independently bill for their services.

- Please fill out and sign the application. (If you received care at multiple Hackensack Meridian Health hospitals, you will need to sign an application for each hospital where you received services.)
- Attach copies of all required documents.
- All documentation is based on the initial date of service.
- If you are 21 years of age or younger and a full time college student, your parent or guardian must fill out the application and provide the necessary supporting documents. Please provide proof of your student status and financial award letters for the current and previous semesters.

If you have any questions regarding the application or documentation that is required to apply, please call a financial counselor at the hospital where you received your services.

- **Hackensack University Medical Center,100 First Street, Ste 300, Hackensack, NJ 07601 (551) 996-4343**
- **Palisades Medical Center, 7600 River Road, North Bergen, NJ, 07047 (201) 854-5092**
- **JFK Medical Center, 65 James Street, Edison, NJ 08820 (732) 321-7534**

For the below hospitals, please call 732-902-7080

- **Jersey Shore University Medical Center, 1945 Route 33, Neptune, NJ, 07753**
- **Ocean University Medical Center, 425 Jack Martin Boulevard, Brick, NJ 08724**
- **Riverview Medical Center, 1 Riverview Plaza, Red Bank, NJ 07701**
- **Southern Ocean Medical Center, 1140 Route 72 W, Manahawkin, NJ 08050**
- **Bayshore Medical Center, 727 N Beers St, Holmdel, NJ 07733**
- **Jane H Booker Family Health Center, 1828 W Lake Ave # 202, Neptune, NJ, 07753**
- **Raritan Bay Medical Center, 530 New Brunswick Ave, Perth Amboy, NJ**
- **Old Bridge Medical Center, % RBMC, 530 New Brunswick Ave, Perth Amboy, NJ**

To further assist us in processing your application for charity care, please only provide copies of the documents listed below which apply to your situation. If the appropriate documentation listed below is not provided or your application is incomplete, we will not be able to process your application. All required documents are based on your Date of Service. Date of Service means the first day you were actually in the hospital.

Personal ID for patient, spouse, children under 18, and full time college students 21 and under

- Choose one for each member of your family: driver's license, birth certificate, Social Security card, passport

Insurance Cards

- Copy the front and back of insurance card

Banking/Asset statements that include the balance on your date of service

- Checking, savings, and debit card account statements
- Deposits over your reported income may require an explanation
- Current documentation for any CD's, IRA's, 401K's, stocks or bonds

Proof of Income for the one month prior to the date of service

- Proof of earned income, including pay stubs or a written signed statement of gross earnings from your employer on business letterhead
- If you are self-employed, a profit and loss statement signed by an accountant is required along with a copy of the tax return for the prior year. If your business is a partnership or corporation, provide a letter from an accountant with your weekly salary draw.
- Proof of unearned income, including but not limited to retirement pension, child support, alimony, VA benefits, Social Security award letter, SSI Award letters for all family members, unemployment or State Disability record or other financial contributions

Proof of Residence prior to the date of service

- Must show street address – <u>NOT</u> a PO Box
- Please choose one of the following: driver's license, copy of lease, utility bill, dated mail with your name and address issued prior to date of service

Patient's attestation: (sign and date all that apply).

- Spouse's attestation if married (sign and date all that apply).

If you have no income, have the enclosed Letter of Support signed by the person with whom you reside (other than a spouse) that is helping to financially support you.

Please mail your application and documents to the address above where you are applying for charity care. (Reminder: charity care is hospital specific so if services were provided at multiple locations, an application needs to be submitted for each location.)

Hackensack Meridian *Health*

New Jersey Hospital Care Assistance Program
Charity Care Application

Check ALL hospitals where you received services:

( ) HUMC ( ) PMC ( ) JFK ( ) JSUMC ( ) OMC ( ) RMC ( ) BCH

( ) SOMC ( ) RBMC ( ) OBMC

SECTION I – PERSONAL INFORMATION

PATIENT NAME (LAST, FIRST, M.I.)		DATE OF BIRTH
DATE OF APPLICATION	DATE OF SERVICE	PREGNANT? ☐ YES ☐ NO
STREET ADDRESS OF PATIENT		TELEPHONE/CELL NUMBER ( )
CITY, STATE, ZIP CODE		*FAMILY SIZE / MARITAL STATUS

ARE YOU A US CITIZEN?	ARE YOU A RESIDENT OF NEW JERSEY?
☐ YES ☐ NO LEGAL RESIDENT SINCE: _____	☐ YES ☐ NO

NAME OF GUARANTOR (If other than Patient)	INSURANCE COVERAGE: ☐ YES ☐ NO INSURANCE CO _____ POLICY #:

OTHER FAMILY MEMBERS	RELATIONSHIP	DATE OF BIRTH	PREGNANT? Y/N	INSURANCE COVERAGE? Y/N
1.				
2.				
3.				
4.				
5.				
6.				

SECTION II- ASSET CRITERIA

ASSETS INCLUDE:

A. Savings Accounts _____

B. Checking Accounts _____

C. Certificates of Deposit / IRA _____

D. Equity in Real Estate (other than primary residency) _____

E. Other Assets, 401K, Stocks and Bonds _____

F. TOTAL _____

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

SECTION III- INCOME CRITERIA

When determining eligibility for hospital care assistance, patient and if applicable, spouse's income are to be used. Parent's income 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, one month or one week of income prior to the date of service.

EMPLOYER NAME:	TOTAL INCOME $

SOURCES OF INCOME:		Weekly	Monthly	Yearly
A. Salary / Wages before Deductions	_____	☐	☐	☐
B. Public Assistance	_____	☐	☐	☐
C. Social Security/Disability Benefits	_____	☐	☐	☐
D. Unemployment & Workman's Comp.	_____	☐	☐	☐
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	_____	☐	☐	☐
M. Other (Strike benefits, training stipends, Military family allotment, estates or trust)	_____	☐	☐	☐

Other source of income: _____

SECTION IV – CERTIFIED 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 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 status, 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 GUARDIAN	**DATE**

FOR OFFICE USE ONLY: Responsibility No insurance coverage _____ %

After insurance coverage_____ %

DATE APPROVED: _____ Effective: _____ Terminates: _____

Evaluator's Signature: _____

Hackensack Meridian *Health*

PATIENT ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION:

1. I attest that as of _____ I have NOT received any income.
   DATE

   _____ _____
   (Patient / Responsible Party) Relationship DATE

2. I attest that I have NO ASSETS (Bank accounts, CD's, etc.) through myself or any other party.

   _____ _____
   (Patient / Responsible Party) Relationship DATE

3. I attest that I am HOMELESS and have been HOMELESS since _____

   _____ _____
   (Patient / Responsible Party) Relationship DATE

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

   _____ _____
   (Patient / Responsible Party) Relationship DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE PATIENT/RESPONSIBILITY PARTY

5. I ATTEST THAT I AM/WAS A NEW JERSEY RESIDENT AT THE TIME SERVICES WERE RECEIVED AND THAT I INTEND TO REMAIN A RESIDENT OF NEW JERSEY.

_____ _____
(Patient / Responsible Party) Relationship DATE

6. I AFFIRM THAT ALL INFORMATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
(Patient / Responsible Party) Relationship DATE

_____
Reviewer

Hackensack Meridian *Health*

SPOUSE ATTESTATION

ONLY SIGN BELOW WHAT MAY APPLY TO YOUR SITUATION:

1. I attest that as of _____ I have NOT received any income.
   DATE

   _____ _____
   (Spouse / Responsible Party) Relationship DATE

2. I attest that I have NO ASSETS (Bank accounts, CD's, etc.) through myself or any other party.

   _____ _____
   (Spouse / Responsible Party) Relationship DATE

3. I attest that I am HOMELESS and have been HOMELESS since _____

   _____ _____
   (Spouse / Responsible Party) Relationship DATE

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

   _____ _____
   (Spouse / Responsible Party) Relationship DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE PATIENT/RESPONSIBILITY PARTY

5. I ATTEST THAT I AM/WAS A NEW JERSEY RESIDENT AT THE TIME SERVICES WERE RECEIVED AND that I INTEND TO REMAIN A RESIDENT OF NEW JERSEY.

_____ _____
(Spouse / Responsible Party) Relationship DATE

6. I AFFIRM THAT ALL INFORMATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
(Spouse / Responsible Party) Relationship DATE

_____
Reviewer

Hackensack Meridian *Health*

LETTER OF SUPPORT

PATIENT: DATE:

DATE OF BIRTH: INITIAL DATE OF SERVICE:

TO BE COMPLETED BY PERSON WHO IS PROVIDING SUPPORT TO THE PATIENT. DOES NOT INCLUDE A SPOUSE LIVING WITH YOU.

I certify that the information listed below is true and correct. I fully understand that giving false information or the failure to give complete information requested can constitute grounds for fraud and Hackensack Meridian Health may take any legal action appropriate. I further understand that I will personally be held responsible if information is falsified, incomplete, or in any way misleading.

Check below whatever applies:

- ☐ The above named person lives with me, and has since **(Date):** _____
- ☐ The above named person was a N.J. resident at the time of the service, has no residency in any other State or Country and intends to remain in the State of NJ.
- ☐ The above named person is not covered by any type of medical insurance including Medicaid or Medicare.
- ☐ The above named person is unemployed at this time and has been for at least one month prior to the date of service indicated above.
- ☐ The above named person does not receive unemployment benefits or any other type of benefits (Disability, SSI, Welfare, etc.)
- ☐ I am providing Food and Shelter for the above named person.
- ☐ I am providing Cash in the amount of $_____per month, to the above name person.
- ☐ The above named person does not live with me but I provide support in the form of:

_____.

_____ _____ Signature

Your relationship to the above named

Address: _____

_____

(City) (State) (Zip Code)

Phone Number: _____