## New Jersey Hospital Care Payment 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

<table>
<thead>
<tr>
<th>1. PATIENT NAME</th>
<th>2. SOCIAL SECURITY NUMBER</th>
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<tr>
<th>3. DATE OF APPLICATION</th>
<th>4. INITIAL DATE OF SERVICE</th>
<th>5. REQUESTED DATE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
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<tr>
<th>6. STREET ADDRESS OF PATIENT</th>
<th>7. TELEPHONE NUMBER</th>
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<tr>
<th>8. CITY, STATE, ZIP CODE</th>
<th>9. FAMILY SIZE*</th>
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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)

13. IS PT OVER 65 YEARS OLD?

- [ ] Yes
- [ ] No
- [ ] CWF Included

14. IS PT COVERED BY INSURANCE?

- [ ] Yes
- [ ] No

### SECTION II - Assets Criteria

15. Individual Assets: 

16. Family Assets: 

17. Assets Include:

A. Cash

B. Savings Account

C. Checking Account

D. Certificate 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.

Reviewed 12-2012
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 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:

<table>
<thead>
<tr>
<th>Last 12 Months</th>
<th>Last 3 Months</th>
<th>Last 1 Month</th>
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<tbody>
<tr>
<td></td>
<td>X 12</td>
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18. SOURCES OF INCOME

A. Salary/ Wages Before Deductions
B. Public Assistance
C. Social Security Benefits/Disability
D. Unemployment & Workmen's Compensation
E. Veteran's Benefits
F. Alimony/ Child Support
G. Other Monetary Support
H. Pension Payments
J. Dividends/Interest
K. Rental Income
L. Net Business Income (self employed/ verified by independent sources)
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 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 changes in status to my income or assets.

16. Signature of Patient or Guarantor  17. Date

X

Reviewed 12 - 2012