NJ Hospital Care Assistance Program(NJHCAPS)

NJ Hospital Care Assistance Program (**formerly known as Charity Care**) is available to every patient regardless of whether they are insured or not. Each patient is given the NJHCAP information at the time of registration. Patients are given the option to apply by mail or come in person to apply. In order to be deemed eligible under the program, patients must meet the following criteria:

- Patient must bring in proof of NJ residency for the date of service.
- Patient must meet income and asset criteria
- Patient must have an existing hospital/clinic bill or be on the schedule for a procedure.
- Patient must be screened for all other government programs before NJHCAP eligibility can be considered.
- Patient may apply for NJHACAP for balances after all of their insurance plans have paid and have left a patient balance. However if a patient has insurance they must follow all policy requirements.
- The NJHCAP application is a standard application for all hospitals. However, additional documentation may be required, depending on a patient's particular circumstance.

In addition to screening for the NJHCAP, Centrastate's Financial Counselors will also screen for all available government programs as well. Due to the recent changes in Healthcare laws, Patients may now be found eligible for insurance through the Affordable Care Act. More information on the Affordable Care act can be found on their website www.healthcare.org

All financial counselors are certified by Medicaid to assist a patient with completing a Medicaid or presumptive eligibility Medicaid application. However, these applications still must be reviewed by either a State Medicaid Worker, County Medicaid worker or HMO Vendor, depending on the type of program each recipient would be eligible for.

After downloading the charity care application, please review the required documentation list and provide all necessary documentation that pertains to your particular case. Once the application has been filled out and all documents acquired, you can either mail your completed application to our office or apply in person at the address listed below.

CentraState Medical Center
901 West Main Street
Freehold, New Jersey 07728
Attn: Financial Counselor

If you have any questions prior to mailing or bringing your application in, please feel free to contact our department at 732-294-2641.

New Jersey Hospital Care Assistance Program
Centrastate Medical Center
901 West Main St., Freehold, NJ 08852
Tel# 732-294-2641 Fax: 732-780-2181

The **New Jersey State Hospital Care Assistance Program** may be available to you to help pay all or part of your medical bill(s) if you qualify. The CentraState Medical Center Patient Accounts Department is happy to help you with the application process. Please see the following list of Documents you will need to provide:

Note: **Family size consists of patient, spouse, minor children under the age of 18, unborn children and any F/T College students 21yrs or younger.

****No internet copies/printouts will be accepted without a company/branch stamp**

Please note that additional information may be required and/or requested once your application is received.

1. **PROOF OF GROSS INCOME, four weeks prior to your initial date of service**, such as:
   - Last four consecutive pay stubs.
   - Letter from employer stating date of hire, hours worked and gross income.
   - Unemployment, workman's comp or disability stubs, for unemployment (**MUST GET LOOPS PRINTOUT STAMPED AND SIGNED)**
   - Social Security award letter, Social Security Disability.
   - If you are Self Employed you need to provide a Business Profit and Loss statement three months prior to date of service and has to be prepared by CPA. (Please do not include Personal expenses)
   - Proof of child support (stubs or printout stamped)
   - Proof of public assistance.
   - Proof of pensions, annuities, etc.
   - Proof of full time status and financial aid for F/T students for the prior 2 semesters from your date of service.

   Proof of income is needed for **patient, spouse, and minor children**. If you have no income, you will need to supply a letter from Whomever is supporting you stating that a) you are not working, and b) they are supporting you by providing food, room & board, as well as how long they have been doing so. This letter must have the name, address and telephone number of the person supporting you

2. **PROOF OF LIQUID ASSETS, on the date of service**, such as:
   - Checking account statement (**all pages) or letterhead from bank** with the reflecting balance.
   - Savings account statement **(all pages) or letterhead from bank** with the reflecting balance.
   - Cash Value of Certificates of deposit (CD's)
   - Value of your stocks, bonds, IRA's, 401k's 403b's or securities.
   - Cash Value of Life Insurance
   - Equity in Real State other than one's primary residence (i.e.: second homes, vacation homes, rental property.

3. **PROOF OF IDENTITY,** for all family members, such as:
   - Valid NJ driver's license.
   - Social Security cards for all family members.
   - Birth Certificates for all family members.
   - Voter registration card
   - Alien Registration card (Green Card)
   - Valid Passport.

4. **PROOF OF NJ RESIDENCY,** for the 30 days prior to your date of service, such as:
   - Valid NJ driver's license.
   - Utility bill (gas, electric, water or landline phone bill addressed to you one month prior to date of service).
   - Letter from someone you live with stating length of time at present address and their utility bill.
   - Lease or letter from landlord.

New Jersey Hospital Assistance Program
APPLICATION FOR PARTICIPATION

PROOF OF IDENTIFICATION, PROOF OF INCOME AND PROOF OF ASSETS MUST ACCOMANY THIS APPLICATION.
SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTSAS THEY WILL NOT BE RETURNED.

SECTION I – Personal Information

1. Patient Name

_____ _____ _____
Last First Initial

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. Current Address of Patient

7. Telephone Number

(__ __ __) __ __ __- __ __ __ __

8. State, Zip Code

9. Family Size*

10. Citizenship

☐ Yes ☐ No ☐ Pending Application

11. Name of Guarantor (if different from patient)

SECTION II – Assets Criteria

(Please list the exact dollar amount of the below items as of the date of service in box # 4 above)

12. Individual Assets: _____

13. Family Assets: _____

14. 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.**

SECTION III – Income Criteria

Upon determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult patient's income and assets must be used for a minor child. *Proof of income and assets must accompany this application.*

Income is based on the calculation of twelve months, three months, one month or one week of income prior to the date of service (Box #4.)

Patient/Family Gross income equals the lesser of the following:

LAST 12 MONTHS		LAST 3 MONTHS X 4		LAST 1 MONTH X 12		LAST 1 WEEK X52
	or		or		or	

15. SOURCE OF INCOME:

		WEEKLY	MONTHLY	YEARLY
A. Salary / Wages before Deductions		☐	☐	☐
B. Public Assistance		☐	☐	☐
C. Social Security Benefits		☐	☐	☐
D. Unemployment & Workman'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 sources		☐	☐	☐
M. Other (strike benefits, training stipends, Military family allotment, income from estates And trusts)		☐	☐	☐
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 Local or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil Penalties.

As 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 in regards to my income or assets.

16. Signature of Patient or Guarantor | **17. Date**

CERTIFICATION

Patient Name: _____ Date: _____

Account Number: _____ DOS: _____

I. MARITAL STATUS/ PATIENT RESPONSIBLE PARTY

___I am single.
___ I am married.
___ I am legally divorced.
___ I am widow/widower.
___ I am legally married, but I have been abandoned by my spouse.
We have lived and maintained separate households since ____/____/____.
We have no financial ties and share no assets. Further I have no knowledge of any spousal assets.

Signed: _____

_____ _____
Spouse Date of Birth

I have physical custody of my dependent child (ren) under the age of 18.

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY SIZE _____NUMBER OF ADULTS_____ NUMBER OF CHILDREN_____

_____ I am legally married to the other parent.
_____ I am legally divorced from the other parent.
_____ I was never legally married to the other parent, nor child support received.

Signed: _____

II. INCOME/ASSETS

___ I, _____, attest to the fact that neither I nor anyone in my filing unit had income _____ prior to this admission.

Signed: _____

___ I, _____, attest to the fact that I nor anyone in my family filing unit have or had any assets _____ prior to this admission.

Signed: _____

III. HEALTH COVERAGE

___ I, _____, certify that I have no health coverage which will cover the cost of services rendered on _____.

Signed: _____

Revised 3/25/99

III. RESIDENCY

___ I have been a resident of the STATE OF NEW JERSEY, the county of _____ since _____. I further attest that I have no other residency in any other state or county, and have the intention of remaining a resident.

___I am not a residency of the STATE OF NEW JERSEY. My admission was the direct result of an Emergency Room admission. I have no health insurance, nor was I enrolled in any Assistance Programs in the state in which I reside.

Misrepresentation of these facts will negate the hospital's right to receive Reimbursement for any charges not covered by Medicaid or Third Party Insurance. If so Requested, I will apply for GOVERNMENT, or other medical assistance for payment of The hospital bill.

Signed: _____ Date: _____

IV. STATEMENT OF MAINTAINENCE

My living arrangements from _____ to _____ are / were as fallows:

_____
_____
_____
_____
_____

I certify that the information listed above is true to the best of my knowledge.

_____ _____
Signature **Date**

I, _____, respectfully submit my Charity Care Application.
Patient/ Responsible Party

_____ _____
Signature **Date**

I, _____, Categorically refuse to apply for Medicaid.
Patient/ Responsible Party

_____ _____
Signature **Date**

/certification **Revised 3/24/99**