TRINITAS
Regional Medical Center

CBIZ

CBIZ KA CONSULTING SERVICES

Patient Name:
Account#
Date of Service:
Balance:

Dear Patient,

Per your request the financial screening application is attached. Please complete all the requested information and return it promptly.

This letter is in reference to your pending account for the services rendered while at Trinitas Regional Medical Center. In cooperation with Trinitas Regional Medical Center, we may be able to assist with your unpaid medical bills. Your account has been referred to me in order to determine your eligibility for our various array of assistance programs that may help cover your charges and pending bills at NO COST TO YOU.

Please bring with you the following pending documents:

Patient and/or family including children under 18:

- ✓ A valid New Jersey drivers license with current address
- ✓ Expired New Jersey drivers license
- ✓ Passports
- ✓ Resident Alien Card
- ✓ Work Authorization card
- ✓ Social Security Card
- ✓ Marriage Certificate (if you are married)
- ✓ Birth Certificates

Proof of Address: Month of –

- ✓ Cable Bill
- ✓ Gas Bill
- ✓ Electricity Bill
- ✓ Water Bill
- ✓ Lease

Proof of Income:

- ✓ Copies of your last 4 pay stubs if you get paid weekly or last 2 if you get paid bi-weekly
- ✓ If you get paid in cash, a letter from your employer on a company letterhead will be required
- ✓ Unemployment or Disability paystubs
- ✓ Letter of Support

Proof of Assets: Month of -

- ✓ Complete bank statement checking and/or savings-all pages for month stated above
- ✓ Direct express and any other direct deposit banking system
- ✓ Print out from bank with bank stamp and signature from bank representative
- ✓ 401k statements

Address: **210 Williamson St. Elizabeth NJ 07201** or **655 East Jersey St. Basement Elizabeth NJ 07201**

Trinitas Regional Medical Center

210 Williamson St.
Elizabeth NJ 07207
908-994-8691
www.trinitas.org

New Jersey Hospital Care Assistance Program

APPLICATION FOR PARTICIPATION

SECTION I - Personal Information

1. PATENT 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. CITIZEN SHIP ☐ Yes ☐ NO ☐ PENDING APPLICATION	11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ ☐ Yes ☐ NO	
12. NAME OF GUARANTOR (If other than the patient)	13. IS PATIENT (SPOUSE, PARENT, OTHER) COVERED BY INSURANCE ☐ YES ☐ NO NAME OF COMPANY _____ ADDRESS _____	

Eligible Family Members, Including Applicant

Name	Date of Birth	SS#	Occupation	Monthly Salary

SECTION II - Assets Criteria

14. Individual Assets: _____
15. Family Assets: _____
16. Assets Include:
    - A. Cash _____
    - B. Saving Accounts _____
    - C. Checking Accounts _____
    - 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

APPLICATION OF 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; 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	OR	LAST 3 MONTHS X 4	OR	LAST 1 MONTH X 12

17. SOURCES OF INCOME

		WEEKLY	MONTHLY	YEARLY
A. **Salary/Wages Before Deductions**	_____	☐	☐	☐
B. **Public Assistance**	_____	☐	☐	☐
C. **Social Security Benefits**	_____	☐	☐	☐
D. **Unemployment & 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 of 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 government 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 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

Patient Attestation

Patient Name: _____ Acct Number/MR#:_____

Date of Service:_____

Please Initial

____I attest that my name is_____.

____My Marital Status is ____Single____Married____Divorced____Widowed
____Separated/No Financial Ties since ____/____/____.

____I and/or my spouse attest I'm a **Resident of New Jersey** since____/____/____ residing at
_____and Intend to Remain.

____I and/or my spouse attest that I am in the U.S.A as a ___**Undocumented Alien**
___**Resident Alien** and Intend to remain as a resident of New Jersey.

____I and/or my spouse attest that I/we are **Homeless** and have been homeless
Since____/____/____.

____I attest that my name is _____, I cannot provide proof of
Identification because:_____

____I and/or my spouse attest I/we **Have Income**. Our gross/cash income is $_____
And we get paid on a _____basis.

____I and/or my spouse attest that I/we have **No Income** since ____/____/___ to ____/____/___.
And have been supported by _____relationship_____.

____I and/or my spouse attest that I do not receive any **Child Support** since ____/____/____
For my child/children.

____I and/or my spouse attest I **Have Assets** on the date of service above for the amount of
Checking $_____savings$_____other$_____

____I and/or my spouse attest that I have **No Assets** as listed on the application.

____I attest I have **No Medical Coverage** through myself or any other party to cover the
Outstanding amount of this bill.

____My **Family Size** is____, including myself, spouse and children under age 18 residing in the
Household (pregnant women account as 2 with proof of pregnancy).

____I attest that all the above information is true and correct.

X_____ X_____

Patient Signature **Date**