RWJBarnabas HEALTH

APPLICATION FOR FINANCIAL ASSISTANCE

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 hereby certify that the information provided for purpose of creating a financial assistance/Charity Care application is correct to the best of my knowledge.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

_____ _____

APPLICANT SIGNATURE DATE

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

PROVIDER NAME: RWJ Barnabas Health

RWJBarnabas HEALTH

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 _____ _____ _____ (Last) (Frst) (MI)		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. CITIZENSHIP ☐ Yes ☐ No ☐ Pending Application	11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF N.J. ☐ Yes ☐ No	
12. NAME OF GUARANTOR (if other than patient)		

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 _____

APPLICATION FOR PARTICIPANT (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	or	LAST 3 MONTHS X4	or	LAST 1 MONTH X12

16. SOURCE 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 & Support	_____	☐	☐	☐
G. Other Monetary Support	_____	☐	☐	☐
H. Pension Payments	_____	☐	☐	☐
I. Dividends / Interests	_____	☐	☐	☐
J. Insurance	_____	☐	☐	☐
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 By Applicant

I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal of 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 for my income or assets.

17. SIGNATURE OF PATIENT OR GUARANTOR	18. DATE

RWJBarnabas HEALTH

Date of initial separation:_____

Legal residence of applicant: _____

_____

Legal residence of spouse: _____

_____

I, _____, certify and attest to the truthfulness of the following:

1. That my spouse and I are separated and no longer reside together.
2. That I have no access to the funds of my spouse.
3. That I receive no support or monies from my spouse.
4. That my spouse and I have no financial ties.
5. That my spouse and I do not mingle or join our funds in any way, including the filing of joint federal or state income tax returns.

Signature:_____ Date:_____

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Date: _____

I_____ state that I am not married to my son's/daughter's/children's father/mother and receive no financial support from him although he provides us with food and shelter.

_____

Signature

I_____ state that I am not married to my son's/daughter's/children's father/mother and receive no financial support for him/her/them.

_____

Signature

I_____ state that I am not married to my son's/daughter's/children's father/mother but I do receive financial support for him/her/them.

_____

Signature

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To Whom It May Concern:

I, the undersigned, _____ (relation to patient)

_____, provide the necessary room, board and other life essentials

for _____ at my residence,

_____, and have been doing

so from _____ to _____.

I am not responsible or able to pay for any hospital or other medical expenses for him/her.

_____ _____

Signature Date

Telephone #: (_____) _____

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Date:_____

To Whom It May Concern:

This is to state that I _____ do **NOT** have the following (please check off what you do **NOT** have):

- ☐ _____ 1040 Income Tax (Federal)
  Year
- ☐ Did Not File
- ☐ Do not work, collect unemployment, disability or receive financial assistance.
- ☐ Checking Account
- ☐ Savings Account
- ☐ CD'S/STOCKS/ I.R.A. PLANS/ 401K
- ☐ Medical/Dental/No Fault Insurance

_____
Signature

Additional Comments:_____

_____

_____

_____

_____

CHARITY CARE CHECKLIST

_____
DATE
Trinitas Regional Medical Center
FACILITY

_____
ACCT#

_____
PATIENT'S NAME

_____
DATE OF SERVICE

In order for Trinitas Regional Medical Center to consider your application for Charity Care, the Department of Health requires that the following information be secured before a determination is made. Please provide our office with the items checked below as soon as possible.

_____ **IDENTIFICATION FOR YOURSELF, SPOUSE & CHILDREN**: Birth Certificate, Social Security Card, Driver's License, Alien Registration Card, Passport, County/Welfare ID card etc.

_____ **PROOF OF RESIDENCY:** from _____. Driver's license, Utility Bill, Copy of Lease/Mortgage Statement, Letter from Landlord, Statement of Support from Caretaker, etc.

_____ **PROOF OF INCOME: from** _____ to _____

- ____ **Wages**: Copies of paystubs or statement from employer on company letterhead with gross weekly, biweekly, or monthly income including date of hire/term or any health coverage information.
- ____ **Unemployment**: Stubs/Printout from the office.
- ____ **Social Security/Pension Awards letter**
- ____ **State/Private/Disability Awards letter**
- ____ **Public Assistance/Child Support/Alimony Verification Letters from City or County agency.**
- ____ **Rental Income:** Copy of lease from tenant.
- ____ **Statement of Support** (must include the name and address of the caretaker and the dates the caretaker provided for the patient.
- ____ **Profit & Loss statement:** From Certified Public Accountant (on their letterhead)

_____ **PROOF OF ASSETS FOR DATE OF SERVICE:**_____

- ____ Checking & Savings Accounts: Please submit a copy of the bank statement which covers the above date. **(Please submit all pages)**
- ____ Value of IRA/401K/Stocks & Bonds/CDs **(Please submit all pages of statement)**
- ____ Equity of Rental Property/Secondary Home

_____ **PLEASE SIGN ATTACHED DOCUMENTS:**

- ____ Charity Care Application
- ____ Pt/Resp Party Attestation
- ____ Spouse Attestation
- ____ Affidavit of Separation
- ____ No Contact Attestation
- ____ Other

When all of the required information has been received in our office, your account will be considered for Charity Care. If you have any questions or problems regarding your application, please feel free to call (856) 330-8041 and ask for _____.