Hackensack Meridian *Health*
Pascack Valley Medical Center

Clear Form

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

1. PATIENT NAME			SOCIAL SECURITY NUMBER
_____ (Last)	_____ (First)	_____ (MI)	___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. DATE OF APPLICATION	4. INITIAL DATE OF SERVICE	5. REQUESTED DATE OF SERVICE
_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year

6. STREET ADDRESS OF PATIENT	7. TELEPHONE NUMBER
	(__ __ __) __ __ __ - __ __ __ __
8. CITY, STATE, ZIP CODE	9. FAMILY SIZE *

10. U.S.CITIZENSHIP	11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ
☐ Yes ☐ No ☐ Pending Application	☐ 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(office use)

15. Individual Assets: _____

16. Family Assets: _____

17. 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 $ 0.00

*** Family size includes self, spouse, and any minor children. A pregnant woman is counted as two family members.**

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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:

Last 12 Months	or	Last 3 Months X4	or	Last 1 Month X12

18. 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. Their 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	$ 0.00 _____	☐	☐	☐

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 change in status in regards to my income or assets.

19. Signature of Patient or Guarantor **20. Date**

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Patient Primary Attestation

Patient Name: _____ **Account Number: _____**

Date of Service: _____ **Address: _____**

_____

Please Initial

____ I and/or my spouse attest I/we have no income and have had no income since ___/___/___ to ___/___/___

____ I and/or my spouse attest I have no assets as listed on the charity care application.

____ I and/or my spouse attest I'm homeless and have been homeless since___/___/___

____ I and/or my spouse attest I/we have no Medical Insurance to cover the outstanding amount for my hospital services.

____ I attest that my name is _____. I cannot provide proof of identification because: _____
(State Reason)

_____

____ I and/or my spouse attest I/we have income. Our gross/cash income is $_____ and we get paid on a _____ basis.
Frequency

____ I and/or my spouse attest I have assets on the date of service above for the amount of $_____.

____ I and/or my spouse attest I'm a resident of New Jersey and intend to keep New Jersey as my residence.
Residing at: _____

____ I attest that I have not made and that I do not intend to make a claim against any third party in which I can seek payment, in whole or in part, for the medical services to which this application relates (including, without limitation, claims for no fault, workers compensation, homeowners, underinsured or uninsured motorist insurance benefits and tort claims). I understand and agree that, if any such claim is made, Hackensack Meridian Health Pascack Valley Medical Center may retract its charity care and seek payment of all charges from me. I also agree to notify Hackensack Meridian Health Pascack Valley Medical Center when a claim is filed.

_____
Patient Signature

_____
Printed Name

_____
Date

Update 05/24/2016