



## 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<br><br>_____  |  | 2. SOCIAL SECURITY NUMBER<br><br>_____ -- _____ -- _____                           |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span>(Last)</span> <span>(First)</span> <span>(MI)</span> </div> |  |  |
| 3. DATE OF APPLICATION<br><br>____ / ____ / ____<br>Month      Day      Year  | 4. INITIAL DATE OF SERVICE<br><br>____ / ____ / ____<br>Month      Day      Year | 5. REQUESTED DATE OF SERVICE<br><br>____ / ____ / ____<br>Month      Day      Year |
| 6. STREET ADDRESS OF PATIENT<br><br>_____   |  | 7. TELEPHONE NUMBER<br><br>(____) _____ - _____                                    |
| 8. CITY, STATE, & ZIP CODE<br><br>_____   |  | 9. FAMILY SIZE*  |
| 10. U.S. CITIZENSHIP<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Pending Application           |  | 11. PROOF OF 3 MONTH RESIDENCY IN THE STATE OF NJ                                  |
| 12. NAME OF GUARANTOR (If other than patient)<br><br>_____  |  |  |
| SECTION II – Assets Criteria  |  |  |
| 13. Individual Assets: _____  |  |  |
| 14. Family Assets: _____  |  |  |
| 15. Assets Include:   |  |  |
| A. Cash   | _____  |  |
| B. Savings Accounts   | _____  |  |
| C. Checking Accounts  | _____  |  |
| D. Certificates of Deposits/I.R.A.  | _____  |  |
| E. Equity in Real Estate (other than primary residence)   | _____  |  |
| F. Other Assets (Treasury Bills, negotiable paper,<br>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**

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 | LAST 3 MONTHS<br>X 4 | LAST 1 MONTH<br>X 12 |
|                | OR                   |                      |
|                | OR                   |                      |

**16. SOURCES OF INCOME**

|   | WEEKLY                   | MONTHLY                  | YEARLY                   |
|---|--------------------------|--------------------------|--------------------------|
| A. Salary/Wages Before Deductions _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Public Assistance _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Social Security Benefits _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Unemployment & Workmen's Compensation _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Veteran's Benefit _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Alimony/Child Support _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Other Monetary Support _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Pension Payments _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Insurance or Annuity Payments _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Dividends/Interest _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Rental Income _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Net Business Income (self-employed/<br>verified by independent source) _____                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Other (strike benefits, training stipends,<br>military family allotmentk, income from<br>estates and trusts. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| N. TOTAL _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

**17. SIGNATURE OF PATIENT OR GUARANTOR**

**18. DATE**