

Charity Care Program Questionnaire

Name: _____

Date of Service: _____

Pt. Account # _____

The Charity Care Program is a program designed to help pay hospital bills. Eligibility is based upon your income and assets prior and up to the date of service. It is the patient's responsibility to provide all necessary documentation in order to process your application. See below.

_____ A letter of denial from Medicaid or copies of the Medicaid or Family Care Card.

_____ Pay stubs or a letter from your employer as proof of income for the thirteen week period prior to and including your date of service, from _____ to _____ inclusive. A form letter can be provided.

_____ A Benefit Letter from Social Security stating the monthly amount as of _____

_____ Proof of income from any and all sources: support payments, welfare, unemployment, pension, stock dividends, and child support payments. Any other income, which helps with daily living, must be provided.

_____ Proof of assets: Checking and Savings account statements or a printout from the bank, which covers the date of service _____.

_____ Letter from the person supporting you, explaining the situation including their relationship to you, address, length and type of support they provide. A form letter can be provided.

_____ Two forms of ID for the patient, one form of ID for all other family members (i.e. Driver's License, Birth Certificate, Social Security Card).

_____ Proof of NJ residency covering the date of service (i.e. Driver's License, an apartment / housing lease, mail must be postmarked).

_____ Other _____

Please provide copies of all requested documents. **Do not send originals through the mail.** If you do not have access to a copier you can bring all the documents to the office and a Financial Counselor will make the copies for you.

If you have any questions please call our office. (609) 835-3017
(609) 835-3009