Charity Care Fee Scale
APPLICATION FOR PARTICIPATION
ELIGIBILITY WORKSHEET

PROOF OF IDENTIFICATION, INCOME, AND ASSETS MUST ACCOMPANY THIS APPLICATION
SEND COPIES OF ALL REQUESTED DOCUMENTS, DO NOT SEND ORIGINALS AS THEY WILL NOT BE RETURNED

Section 1 – PERSONAL INFORMATION

SOCIAL SECURITY # _____

1. PATIENT NAME _____ 2. DATE OF BIRTH _____

3 DATE OF APPLICATION _____/_____/_____ 4. INITIAL DATE OF HOSPITALIZATION _____ 5. NAME OF HOSPITAL _____

6. STREET ADDRESS OF CLIENT (Attach list of additional prior addresses, if necessary) _____ 7. TELEPHONE NUMBER _____

CITY, STATE ZIP CODE 9. FAMILY SIZE *

10. COUNTY OF APPLICATION
( ) COUNTY of _____ ( ) STATE _____ 11. SETTLEMENT STATUS _____

12. NAME OF LEGALLY RESPONSIBLE RELATIVE (LRR) ( ) MOTHER ( ) FATHER

(LAST) (FIRST) (MI)

_____ _____ ____

SECTION 2 - 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 resident)
_____

F. Other Assets:
(Treasury bills, Negotiable paper, Corporate stocks and bonds)
_____

G. TOTAL
$0.00
_____

*Family size includes self, spouse, minor children and adults for whom the applicant is legally responsible; a pregnant woman counts as two family members.

BFSP123A/1 (09/06/2005)

LAST NAME: _____ FIRST NAME: _____

DOCKET # : _____ HISTORY: _____

SECTION 3- INCOME CRITERIA

When determining eligibility for an adult, assets of the family will be considered, but only income of the applicant is used. For a minor child, assets and income of the parent(s) must be used. *Proof if income must accompany this application.*

Income is based on the calculation of twelve months, three months, or one month of income prior to date of service Please choose only one.

Client/family Gross income equals the lesser of the following.

LAST 12 MONTHS	or	LAST 3 MONTHS	or	LAST 1 MONTH
1		4		12
◯		◯		◯

16. 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	$0.00	◯	◯	◯

SECTION 4 – CERTIFICATION BY APPLICANT OR COUNTY ADJUSTER

I understand that the information, which I submit, is subject to verification by the appropriate County officials and the State Government. Willful misrepresentation of these facts or refusal to apply for third party insurance benefits or medical assistance program that will pay an amount toward the hospital bill will make me liable for all hospital charges.

I verify that the above information regarding my family size, income, and assets is true and correct.

I understand that is my responsibility to advise the county adjuster of any changes in status in regard to my income or assets.

17. SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE RELATIVE (LRR) 18. DATE _____

In lieu of the patient's/LRR's signature the county adjuster, or their designee, may attest to the calculation of the above information through an authorized certification signature of the patient's/LRR's signature cannot be readily obtained. However, this certification option after all possible means have been attempted to obtain the patients/LRR's signature to certify information accuracy.

19. ATTESTATION OF COUNTY ADJUSTER/OFFICE STAFF MEMBER 20. DATE _____

CLIENT / RESPONSIBLE PARTY ATTESTATIONS

Patient Name: _____ Date: _____

Docket # _____ History # _____

Responsible Party Name: _____ Relationship: _____

Account number: _____ Date of Service: _____

PLEASE PLACE YOUR INITIALS TO THE LEFT OF THE ATTESTATIONS THAT APPLY.

_____ I attest that I do not wish to apply for "Charity Care". I understand that I am responsible for the cost of my hospital care.

_____ I attest that I am single.

_____ I attest that I am married. Spouse's name _____ D.O.B _____

_____ I attest that I am legally divorced.

_____ I attest that I am a widow / widower.

_____ I attest that I have _____ dependent children who reside with me.

_____ I attest that I am legally married to my child / children's father / mother.

_____ I attest that I am legally divorced from my child / children's father/ mother.

_____ I attest that I was never married to my child /children's father / mother.

_____ I attest that I do not receive child support.

NAME	D.O.B.
_____	_____
_____	_____
_____	_____
_____	_____

_____ I attest that I had no income for _____ months immediately preceding my admission.

_____ I attest that I had no assets at the time of my admission or for _____ months prior.

_____ I attest that I have no insurance or cover hospital services received on _____.

_____ I attest that I have been a New Jersey resident since_____ and intend to remain in this State for the foreseeable future.

_____ I attest that my income is such that I do not file income ta.

_____ I attest that I am homeless.

_____ I attest that I am not a New Jersey resident. I was admitted to the hospital as the direct result of an emergency.

_____ I attest that I was Screened and advised of my eligibility for New Jersey Medicaid, but I categorically refused to apply.

_____ **I attest that the information given is true and correct to the best of my knowledge.**

Signature: _____ Date: _____

Print Form