NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

APPLICATION FOR PARTICIPATION

Dear Applicants:

To participate in the New Jersey Hospital Care Assistance program, you will need to fill out an application form and provide your scheduled date for service. We are unable to process any applications that do not include a scheduled service date.

The program application requires specific documentation and we have provided a list of needed documentation with the application. You must have proof of identification as well as documents that state your income and assets. If you do not provide these materials when you submit your application, your application will be immediately denied. Please make copies of your documentation as we will not return your forms to you.

If you prefer to visit our office to drop off your application and documentation, please note that our office is not at the hospital's main campus. Patient Financial Services is located at The Valley Hospital's Dorothy B. Kraft Center, 15 Essex Road, 4th Floor, Suite 404, Paramus, NJ, 07652.

If you have any questions, please contact the Patient Financial Services Department at 201-291-6080. We look forward to serving you.

New Jersey State Department of Health
Health Care for the Uninsured Program

NEW JERSEY HOSPITAL CARE PAYMENT ASSISTANCE FACT SHEET

Mikie Sherrill
Governor

Dr. Dale G. Caldwell
Lt. Governor

Dr. Raynard E. Washington
Acting Commissioner

WHAT IS THE HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM?

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction. Hospital financial counselors can answer an applicant's questions about which services are covered by the New Jersey Hospital Care Assistance Program.

WHERE DOES FUNDING FOR HOSPITAL CARE PAYMENT ASSISTANCE COME FROM?

The source of funding for hospital care payment assistance is through the Health Care Subsidy Fund administered under Public Law 1997, Chapter 263.

WHO IS ELIGIBLE FOR HOSPITAL CARE PAYMENT ASSISTANCE?

Hospital care payment assistance is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: and
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and
3. Meet both the income and assets eligibility criteria listed below.

Hospital assistance is also available to non-New Jersey residents, subject to specific provisions. Note that the Hospital Care Payment Assistance Program is not considered health insurance.

Income Criteria

Income as a Percentage of HHS Poverty Income Guidelines	Percentage of Charge Paid by Patient
less than or equal to 200%	0%
greater than 200% but less than or equal to 225%	20%
greater than 225% but less than or equal to 250%	40%
greater than 250% but less than or equal to 275%	60%
greater than 275% but less than or equal to 300%	80%
greater than 300%	100%

If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered hospital care payment assistance.

Assets Criteria

Individual assets cannot exceed $7,500 and family assets cannot exceed $15,000. Should an applicant's assets exceed these limits, he/she may "spend down" the assets to the eligible limits through payment of the excess toward the hospital bill and other approved out-of-pocket medical expenses.

HOW ARE INDIVIDUALS MADE AWARE OF THE AVAILABILITY OF HOSPITAL CARE PAYMENT ASSISTANCE?

Hospitals post signs in English, Spanish and any language which is spoken by 10% or more of the population in the hospital's service area. These signs are posted in appropriate areas of the facility such as the admissions area, the business office, outpatient clinic areas, and the emergency room. The sign informs patients of the availability of hospital assistance and reduced charge care, gives a brief description of the eligibility criteria, and directs the patient to the business office or admissions office of the hospital. Every patient should receive a written notice of the availability of hospital care payment assistance and medical assistance.

WHAT ARE THE SCREENING PROCEDURES FOR THIRD PARTY PAYERS AND MEDICAID?

All charity care applicants must be screened by the hospital to determine potential eligibility for any third-party insurance benefits, Medicaid or other medical assistance programs that might pay towards the hospital bill.

Patients should only apply for the hospital care payment assistance program when they are determined to be ineligible for Medicaid or any other medical assistance programs. Patients are responsible to obtain a financial screening from other medical assistance programs in a timely manner.

Once the hospital has informed the patient about other medical assistance and/or makes the referral properly, if the patient fails to cooperate or does not go for screening in a timely manner, the hospital has the option to bill the patient and pursue collection efforts, regardless of eligibility for hospital care payment assistance.

HOW DOES SOMEONE APPLY FOR HOSPITAL CARE PAYMENT ASSISTANCE?

The patient or prospective patient must apply for hospital care payment assistance at the hospital from which he/she plans to obtain or has obtained services. The patient should apply at the business office or admissions office of the hospital. The patient or responsible party must answer questions related to his/her income and assets, as well as provide documentation of the income and assets. The hospital will make a determination of whether the applicant is eligible as soon as possible, but no more than ten working days from the time a complete application is submitted. If the request does not include adequate documentation to make a determination, the request shall be denied. The applicant will then be allowed to present additional documentation to the hospital. The applicant has up to one year from the date of service to apply for hospital assistance and provide the hospital with a completed application. Applicants found ineligible may reapply at a future time when they present themselves for services and believe their financial circumstances have changed.

The Department of Health has a toll-free number to assist with any questions or concerns. Please call the Health Care for the Uninsured Program during business hours at 1-866-588-5696 or 609-292-4709.

THE VALLEY HOSPITAL
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REQUIREMENT LIST

Name of Patient: _____
Date of 1st Service: _____
Account #: _____

Dear Applicant/Guarantor

Enclosed please find an application for the New Jersey Hospital Care Assistance program. Please complete all items as they pertained to your financial situation at the **time of service**. In addition to the signed application, you must include all of the following documentation for all siblings in the family size. (**This includes spouse and children only**) **If income is involved you have a choice of providing 4 weeks,13 weeks or 12 months prior to date of service. Also send your most recent Federal income tax returns.**

Employed applicant
- proof of income (consecutive pay stubs or a letter from the employer verifying gross income)
- statements written by employer if wage earned is paid in cash
- if no letter head available from employer, must provide letter with name, address and phone number or business card attached

Self employed applicant
- must provide a statement from a certified public accountant verifying your gross income, including a list of expenses, then net income. (same information is required for those who had a loss in their business net income total and explanation of how supporting yourself/family if no income)
- if no accountant and tax returns are self prepared, please request transcript from IRS

Unemployed applicant
- unemployment stubs or the unemployment letter indicating weekly benefits
- letter from person providing full financial support if no income
- if monetary support is given to you, need letter from person indicating amount of money provided
- workmen's compensation stubs
- disability benefits or SSI benefits, please note that all family members receiving benefits must provide this documentation

Retired applicant
- social security benefits yearly statement or letter from social security office indicating monthly benefit
- pension or veteran's benefits, may provide stubs or letters from the company

Student applicant

- if 18-21 years old, **need to provide parents income and assets if full time student in college**
- please provide any grants or scholarships given to you for the semester as date of service
- if 18-21 years old and not in school or part time only, may apply on your own.

Homeless applicant

- place your initials on the sections which pertain to you and signed the attached homeless form

Separated applicant – Must provide all documents to proof no financial tie with ex-spouse

- attestation from applicant confirming is separated and how long
- lease, dead or letter from landlord he/she no longer lives with you
- bank statement for date of service or attestation stating have no bank accounts
- most recent tax returns

Other type of income

- child support and alimony (if any) , may provide divorce papers or court order statement indicating amount received
- rental income for more than 1 family house, need letter from accountant verifying gross income, expenses, then net rental income for the last 4 weeks or 13 weeks prior to date of service.

Assets- Must provide assets for all family siblings in the household

- copies of bank statements showing balance as date of service. This includes checking account, savings account, CD's, IRA, retirement funds, stocks and bonds, equity in real estate **(other than primary residence)** If you have more than one property besides your primary residence it will be consider as an asset.

Proof of residency in New Jersey- May provide one of the following documents: PO BOX not acceptable

- copy of driver's license
- utility bill with your name/address for date of service
- lease/deed
- letter attached needs to be notarized from person who you live with/also a copy of his or her driver's license or utility bill attached.

Identification- May provide one of the following documents:
(Need to provide identification for all family members in the household)

- valid driver's license
- U.S resident alien card (green card)
- Passport or visa
- Social security card or birth certificate

If qualify for assistance such as 65 years-older, blind, disabled or pregnant women, you must contact your local Board of Social Services or Social Security office in your county to apply before the program is applicable. For all uninsured children in the family from 0-18 years old, you must contact the NJ FamilyCare program at 1800-701-0710. No charity care applicable for newborn.

Please be advised that any incomplete documentation or final eligibility determination from other programs will delay the application process and require us to deny your application until the appropriate documentation is received.

Should you have any questions concerning eligibility requirements, please contact the Patient Financial Services Department at (201) 291-6080 for a verbal screening.

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) (FIRST) (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 NJ

☐ 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 _____

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

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 (s') income and assets must be used for a minor child. *Proof of income must be accompany this application*.

Income is based on 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 X 4	or	LAST 1 MONTH X 12

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/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	_____	☐	☐	☐

SECTION IV - Certification By Application

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

THE VALLEY HOSPITAL
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PATIENT/RESPONSIBLE PARTY
ATTESTATION

PATIENT NAME: _____ **DATE:** _____

RESPONSIBLE PARTY NAME: _____ **RELATIONSHIP:** _____

ACCOUNT NUMBER: _____ **DATE OF SERVICE:** _____

Please place initials to the left of the attestations that apply.

_____ I attest that I am single.
_____ I attest that I am married. Spouse's name _____ and date of birth _____.
_____ I attest that I am legally divorced.
_____ I attest that I am a widow / widower.
_____ I attest that I have been separated from my spouse since _____.
_____ I attest that I have ____ dependent children who reside with me. Please include dependent children from 0-21 year's old if full time student only.

LIST NAMES OF DEPENDENTS	DATE OF BIRTH

_____ I attest that I do not receive alimony.
_____ I attest that that I am not legally married to my child / children's father / mother.
_____ I attest that I receive full financial support from my child / children's father / mother.
_____ I attest that I do not receive child support and I do not know of his / her whereabouts.
_____ I attest that I do receive child support from my child/children's father / mother.
_____ I attest that the information given is true and correct to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____

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PATIENT ATTESTATION

INCOME VERIFICATION

This is to state that I ☐ have never worked

☐ have not worked since _____

☐ am retired

☐ am on Disability

ASSETS VERIFICATION

This is to state that I have (a) ☐ checking account ☐ savings account

☐ other financial assets ☐ no financial assets ☐ unspent loans(s) ☐ cash only

INSURANCE VERIFICATION

☐ This is to state that I do not have any medical insurance of any kind. I am not being medically treated for any injury related to a motor vehicle, job related, or personal injury case.

FEDERAL INCOME TAX RETURN

☐ This is to state that I did not file a federal income tax return for _____ (year).

NJ RESIDENCY

☐ I currently live in New Jersey and intend to live in New Jersey permanently.

****

PRINT NAME: **DATE:**

SIGNATURE:

THE VALLEY HOSPITAL
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SPOUSE ATTESTATION

INCOME VERIFICATION

This is to state that I ☐ have never worked

☐ have not worked since _____

☐ am retired

☐ am on Disability

ASSETS VERIFICATION

This is to state that I have (a) ☐ checking account ☐ savings account

☐ other financial assets ☐ no financial assets ☐ unspent loans(s) ☐ cash only

INSURANCE VERIFICATION

☐ This is to state that I do not have any medical insurance of any kind. I am not being medically treated for any injury related to a motor vehicle, job related, or personal injury case.

FEDERAL INCOME TAX RETURN

☐ This is to state that I did not file a federal income tax return for _____ (year).

NJ RESIDENCY

☐ I currently live in New Jersey and intend to live in New Jersey permanently.

****

PRINT NAME: **DATE:**

SIGNATURE:

THE VALLEY HOSPITAL
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STATEMENT OF SUPPORT

I, the undersigned _____am the_____
(Person supporting patient) (Relationship to patient)

of _____. I recognize him/her and attest that he/she
(Patient)

Resides / resided with me at the following address _____

_____ from _____ to _____
(Date) (Date)

During that time I provided **food, shelter, and basic necessities.**

I am in no way responsible for his / her medical bills.

Signature: _____ Date: _____
(Person supporting patient)

I may be reached at _____ if you have any questions.
(Phone number)

THE VALLEY HOSPTIAL
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PROOF OF NJ RESIDENCY

Please use this attestation if you don't have any type of documentation to proof NJ residency such as driver's license, utility bill, lease, etc.) The person attesting to this letter must provide proof of NJ residency.

I, _____, certify that _____

(Name of person patient resides with) (Name of patient)

is/are a permanent(s) resident of the State of New Jersey and permanently reside(s)

at _____ with me.

(Address of person patient resides with)

I understand that if this information is later determined to be inaccurate, I may be subject to penalty for perjury and may be required to repay the cost of care rendered to my relative(s) through The Valley Hospital.

_____
SIGNATURE

Sworn and subscribed before

me this _____ day of _____, 20_____

_____
Notary

THE VALLEY HOSPITAL
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AFFIDAVIT OF SEPARATION

PATIENT NAME: _____ **DATE:** _____

RESPONSIBLE PARTY NAME: _____ **RELATIONSHIP:** _____

ACCOUNT NUMBER: _____ **DATE OF SERVICE:** _____

I hereby depose and state that I have been separated from my spouse since _____. Since that time we have maintained and resided in separate households. We have no financial ties whatsoever:

_☐_ I attest that I have no joint bank accounts with my estranged spouse.
_☐_ I attest we do not share a lease or have joint property.
_☐_ I attest we have not filed a joint income tax return since _____.
_☐_ I have attached a copy of my last income tax return.
_☐_ I have not attached a copy of my last income tax return because I have not filed income taxes for the following years _____.

My reason for not filing income taxes is because:

_____

_____

_____

_____

I attest that foregoing information is true and correct to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____

Authorization for Asset/Credit Investigation

I/we _____

residing at _____

hereby authorize the law firm of Celentano, Stadtmauer & Walentowicz, LLP, Notchview Office Park, 1035 Route 46 East, Suite 208, PO Box 2594, Clifton, New Jersey 07015, on behalf of The Valley Hospital ("Valley"), to conduct an asset and credit investigation in connection with my/our application to participate in the New Jersey Hospital Care Payment Assistance Program, otherwise known as charity care ("charity care").

In connection with our application to receive charity care, I/we expressly authorize the firm of Celentano, Stadtmauer & Walentowicz, LLP, to conduct credit investigations through Experian including, but not limited to, obtaining credit reports about me/us.

In connection with our application to receive charity care, I/we also agree to provide the firm of Celentano, Stadtmauer & Walentowicz, LLP, with any and all documentation requested in support of my/our application.

Signature _____ Date _____

Signature _____ Date _____