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.

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.

Income Criteria

<table>
<thead>
<tr>
<th>Income as a Percentage of HHS Poverty Income Guidelines</th>
<th>Percentage of Charge Paid by Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than or equal to 200%</td>
<td>0%</td>
</tr>
<tr>
<td>greater than 200% but less than or equal to 225%</td>
<td>20%</td>
</tr>
<tr>
<td>greater than 225% but less than or equal to 250%</td>
<td>40%</td>
</tr>
<tr>
<td>greater than 250% but less than or equal to 275%</td>
<td>60%</td>
</tr>
<tr>
<td>greater than 275% but less than or equal to 300%</td>
<td>80%</td>
</tr>
<tr>
<td>greater than 300%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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 to determine the potential eligibility for any third party insurance benefits or medical assistance programs that might pay towards the hospital bill.

Patients may not be eligible for the hospital care payment assistance program until they are determined to be ineligible for any other medical assistance programs.

Patients are responsible to obtain a financial screening from the hospital in a timely manner. Usually, a patient must apply for Medicaid within 3 months from the date of hospital services.

Once the hospital has informed the patient about 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 and Senior Services 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 1-866-588-5596.
New Jersey Hospital Care Assistance Program
Application for Participation

To All Applicants:

Proof of identification, income and assets **must accompany** this application. For your assistance a requirement list is attached to the application. Please read it carefully and send copies of **all requested** documents pertaining to you. Please do not send original documents as they **will not** be returned.

Please be advised that any incomplete documentation or application will be denied.

Thank you for choosing The Valley Hospital.
Requirements for the NJ Financial Assistance Program

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 13 weeks or 4 weeks 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
Requirements for the NJ Financial Assistance program (cont.)

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 yearsOLDER, 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 our Credit and Collection department at (201) 291-6080 for a verbal screening

Sincerely,

Financial Counselor 10/08
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.

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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 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:

<table>
<thead>
<tr>
<th>LAST 12 MONTHS</th>
<th>LAST 3 MONTHS X 4</th>
<th>LAST 1 MONTH X 12</th>
</tr>
</thead>
</table>

16. SOURCE OF INCOME

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>WEEKLY</th>
<th>MONTHLY</th>
<th>YEARLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Salary/Wages Before Deductions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Public Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Social Security Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Unemployment &amp; Workmen’s Compensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Veteran’s Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Alimony/Child Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Other Monetary Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Pension Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Insurance or Annuity Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Dividends/Interest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Rental Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Net Business Income (self employed/verified by independent source)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Other (strike benefits, training stipends, military family allotment, income from estates and trusts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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Statement of Support

I, the undersigned __________________________ am the __________________________ (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: __________________________

I may be reached at __________________________ if you have any questions.
(phone number)
VALLEY HOSPITAL
NJ HOSPITAL CARE ASSISTANCE PROGRAM

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 ___________________________
VALLEY HOSPITAL
NJ HOSPITAL CARE ASSISTANCE PROGRAM

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 loan(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 ____________________________
I, ___________________________, certify that my family member(s) ___________________________ is/are a permanent resident(s) of the State of New Jersey and permanently reside(s) at ___________________________ with me.

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 Valley Hospital.

__________________________________________
Signature

Sworn and subscribed before me this ________ day of ____________, 200__

__________________________________________
Notary
Dear Charity Care Applicant:

In connection with your application to participate in the New Jersey Hospital Care Assistance Program, otherwise known as Charity Care, The Valley Hospital may require some additional information concerning credit and/or asset verification. This information may be reviewed so that we may be in a position to make an adjudication regarding your Charity Care application.

Depending on the outcome of this review, we may require additional information to be supplied by you.

Please sign the bottom of this form and return it to us along with your completed Charity Care application.

Thank you.

__________________________________________  __________________________
Signature of applicant                          Date