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

NEW JERSEY HOSPITAL CARE PAYMENT ASSISTANCE FACT SHEET

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Governor

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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

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 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 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.

Holy Name Medical Center

Patient Name _____ **Date** _____

Account # _____ **Date of Service** _____

New Jersey Hospital Care Assistance Program funds are available to you to pay all or part of your medical bill(s) if you qualify. Holy Name Medical Center's patient financial services will be happy to assist you in your application process. The NJ State Department of Health, Healthcare for the Uninsured Program, requires that the following information be secured before a determination is made.

Patients are required to submit at least one (1) document from each of the four (4) categories listed below. If married, information is required for spouse as well.

_____ **Identification** (for family example, patient, spouse, minor children)

- Birth Certificates,
- Social Security card,
- Driver's License,
- Passport, Alien Registration, etc.

_____ **Proof of Residency from** _____.

- Driver's license, Utility Bill
- Copy of Lease/Mortgage statement,
- Statement of Support from Caretaker, etc.
- Address Certification

_____ **Proof of Income**: from _____ to _____

- Last four consecutive pay stubs **PRIOR TO THE DATE OF SERVICE**
- Letter from employer (Must have employer's name, address, telephone number, hire date and weekly, bi-weekly or monthly gross earnings
- Unemployment Loops
- Disability Income
- Social Security Award Letter for _____ benefits
- Monthly Pension
- Self Employed Profit and Loss statement from CPA three months prior to date of service
- General Assistance benefit letter
- Child Support
- Rental Income
- Monetary Support
- Support letter with **proof of address from supporter**

_____ **Proof of Assets that covers date of service** _____ (Must have all pages of statement(s))

- Checking Account Statement
- Savings Account Statement
- Stocks, Bonds, or securities
- Life Insurance
- 401K

_____ **Please Sign Attached Documents**

____ Charity Care Application ____ Patient/Guarantor Attestation

____ Other _____

Please call to make an appointment. If you have any questions you may reach us at 201-833-3157 Monday -Friday 8:30am-2:30pm.

Charity Care Appointment

Date: _____ **Time** _____

***** *Charity Care does not cover Physician Fees* *****

New Jersey Hospital Assistance Program
APPLICATION FOR PARTICIPATION

PROOF OF IDENTIFICATION, PROOF OF INCOME AND PROOF OF ASSETS MUST ACCOMANY THIS APPLICATION.
SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTSAS THEY WILL NOT BE RETURNED.

SECTION I – Personal Information

1. Patient Name

Last _____ First _____ Initial _____

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. Current Address of Patient

7. Telephone Number

(___ ___) ___ ___-___ ___ ___ ___

8. State, Zip Code

9. Family Size*

10. Citizenship

☐ Yes ☐ No ☐ Pending Application

11. Name of Guarantor (if different from patient)

SECTION II – Assets Criteria

(Please list the exact dollar amount of the below items as of the date of service in box # 4 above)

12. Individual Assets: _____

13. Family Assets: _____

14. 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.

SECTION III – Income Criteria

Upon determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult patient's income and assets must be used for a minor child. *Proof of income and assets must accompany this application.*

Income is based on the calculation of either twelve months, three months, one month or one week of income prior to the date of service (Box #4.)

Patient/Family Gross income equals the lesser of the following:

LAST 12 MONTHS		LAST 3 MONTHS X 4		LAST 1 MONTH X 12		LAST 1 WEEK X52
	or		or		or	

15. SOURCE OF INCOME:

		WEEKLY	MONTHLY	YEARLY
A. Salary / Wages Before Deductions		☐	☐	☐
B. Public Assistance		☐	☐	☐
C. Social Security Benefits		☐	☐	☐
D. Unemployment & Workman'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 sources		☐	☐	☐
M. Other (strike benefits, training stipends, Military family allotment, income from estates And trusts)		☐	☐	☐
Total		☐	☐	☐

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 Local or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

As 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 changes in status in regards to my income or assets.

16. Signature of Patient or Guarantor

17. Date

Holy Name Medical Center

Patient / Guarantor Attestation

Patient Name: _____ **Date:** _____

Responsible Party Name: _____ **Relationship:** _____

Account Number: _____ **Date of Service:** _____

Please place initials to the left of attestations that apply

_____ I attest that I am Single.
_____ I attest that I am married. Spouses' name _____ D.O.B _____
_____ 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 _____ and have no financial ties.
_____ I attest that I have ____ of dependent children who reside with me.

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ 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.
_____ 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 to cover hospital services received on _____.
_____ I attest that I have been a New Jersey resident since _____ and intend to remain in the this state for the foreseeable future.
_____ 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 refused to apply.
_____ I attest that the information given is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Holy Name Medical Center

New Jersey Hospital Care Assistance Program Credit Report Release

Dear Patient:

In order to process your application to participate in the New Jersey Hospital Care Assistance Program, also known as Charity Care, Holy Name Medical Center may require some additional information concerning credit and/or asset verification. We need your permission to obtain this Credit Report. If needed, we may use this to verify the information offered by you on your application.

Please sign the bottom of this form and return it to us along with your completed application. **Failure to sign and return this form may cause your application to be denied.**

Thank you for your anticipated cooperation.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature if other than Applicant **Relationship to Patient**