UNIVERSITY MEDICAL CENTER OF PRINCETON AT PLAINSBORO
NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

REQUIREMENT LIST

To further assist us in processing your application for Charity Care, please provide copies of the documents listed below which pertain 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 include your most recent Federal income tax returns.

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

Insurance Card: both front and back

Identification: Need to provide identification for all family members in the household. May provide one of the following documents for each family member: Valid driver's license, U.S. resident alien card (green card), passport or visa, social security card or birth certificate.

Proof of Residency in New Jersey Prior to Your Date of Service: 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 of support attached needs to be notarized from person who you live with/also a copy of his/her driver's license or utility bill attached, or dated mail with your name and address issued prior to date of service.

Assets: Must provide assets for all family siblings in the household.
Copies of bank statements showing balance as of date of service. If the statement is a printout, have it stamped and signed by the financial institution representative. This includes checking account, savings account, debit card account statements, CDs, 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 considered an asset. Deposits over your reported income may require an explanation.

Proof of Income - Employed Applicant:
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 letterhead is available from employer, must provide letter with name, address and phone number or business card attached. Proof of unearned income, including but not limited to retirement pension, child support, alimony, VA benefits, Social Security Award letter, SSI Award letters for all family members, unemployment or State Disability record or other financial contributions. Complete copy of your tax return for last year.

Proof of Income – Self-Employed Applicant:
If you are self-employed, you must provide a statement from a certified public accountant verifying your gross income, including a list of expenses, then net income. (The 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 a transcript from IRS.

Attestation Documents:
Attestation Document - Patient must sign and date all that apply.
Spouse's Attestation Document - Spouse must sign and date all that apply.
Letter of Support - must be signed by the person with whom you reside (other than a spouse) that is helping to support you.

Should you have any questions regarding eligibility requirements, please contact the PHCS Financial Counselor at 609-853-7852.

Please mail your completed application and supporting documents to:
UMCPP's Patient Access Services, Financial Counselor, One Plainsboro Road, Office #T1144, Plainsboro, New Jersey 08536;
Or deliver in person to the Financial Counselor, Patient Access Services, located near the Atrium on the first floor or at 609-853-7852, Monday through Friday from 7:30 AM to 4:00 PM.

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

NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

PATIENT ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION

1. I attest that as of _____ I have NOT received any income or filed any income tax returns. DATE

_____ _____
Patient/Responsible Party Relationship DATE

2. I attest that I have NO ASSETS (Bank accounts, CDs, etc.) through myself or any other party.

_____ _____
Patient/Responsible Party Relationship DATE

3. I attest that I am HOMELESS and have been HOMELESS since _____
DATE

_____ _____
Patient/Responsible Party Relationship DATE

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

_____ _____
Patient/Responsible Party Relationship DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE PATIENT/RESPONSIBLE PARTY

5. I attest that I am/was a NEW JERSEY RESIDENT at the time services were received and that I intend to remain a Resident of New Jersey.

_____ _____
Patient/Responsible Party Relationship DATE

6. **I AFFIRM THAT ALL INFORMATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

_____ _____
Patient/Responsible Party Relationship DATE

_____
Interviewer

NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

SPOUSE ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION

1. I attest that as of _____ I have NOT received any income or filed any income tax returns. DATE

_____ _____
Spouse/Responsible Party DATE

2. I attest that I have NO ASSETS (Bank accounts, CDs, etc.) through myself or any other party.

_____ _____
Spouse/Responsible Party DATE

3. I attest that I am HOMELESS and have been HOMELESS since _____
DATE

_____ _____
Spouse/Responsible Party DATE

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

_____ _____
Spouse/Responsible Party DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE SPOUSE/RESPONSIBLE PARTY

5. I attest that I am/was a NEW JERSEY RESIDENT at the time services were received and that I intend to remain a Resident of New Jersey.

_____ _____
Spouse/Responsible Party DATE

6. **I AFFIRM THAT ALL INFORMATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

_____ _____
Spouse/Responsible Party DATE

_____
Interviewer

NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

STATEMENT OF SUPPORT

TO BE COMPLETED BY PERSON WHO IS PROVIDING SUPPORT TO YOU.
(DOES NOT INCLUDE A HUSBAND/WIFE, LIVING WITH YOU.)

I certify that the information listed below is true and correct. I fully understand that giving false information or the failure to give complete information requested can constitute grounds for fraud and Princeton HealthCare System may take any legal action appropriate. I further understand that I will personally be held responsible if information is falsified, incomplete, or in any way misleading.

I, the undersigned _____ am the _____
Person supporting patient Relationship to patient

of _____. I recognize him/her and attest that
Patient

he/she resides/resided with me at the following address _____

_____ from _____ to _____
Date Date

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

I am providing cash in the amount of $ _____ per month to the above named person.

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

Signature _____Date _____
Person supporting patient

Address: _____

_____

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

NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

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 _____