St Joseph's Healthcare System
New Jersey's Premier Catholic Healthcare System

APPLICATION FOR PARTICIPATION

PROOF OF IDENTIFICATION, PROOF OF INCOME, PROOF OF RESIDENCY 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 1 - Personal Information

1. Patient Name

(Last)

(First)

(MI)

2. Social Security Number

3. Date of Application

4. Initial Date of Services

5. Requested Date of Service

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 Residency in the state of NJ

- ◯ YES
- ◯ NO

12. Name of Guarantor (if other than patient)

13. Is Patient over 65 Years Old?

- ◯ YES
- ◯ NO
- ◯ CWF INCLUDED

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

SECTION II - Assets Criteria

14. Individual Assets:

15. Family Assets:

16. Assets Include:

A. Cash

B. Savings Account

C. Checking Account

D. Certificate 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

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 the calculation of either twelve months, three months, or one month of income prior to the date of services.

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

Last 12 Months

or

Last 3 Months X 4

or

Last Month X 12

15. Sources of Income

A. Salary/Wages Before Deductions

- ◯ Weekly
- ◯ Monthly
- ◯ Yearly

B. Public Assistance

- ◯ Weekly
- ◯ Monthly
- ◯ Yearly

C. Social Security Benefits/Disability

- ◯ Weekly
- ◯ Monthly
- ◯ Yearly

D. Unemployment & Workmen's Compensation

- ◯ Weekly
- ◯ Monthly
- ◯ Yearly

E. Veteran's Benefits

- ◯ Weekly
- ◯ Monthly
- ◯ Yearly

F. Alimony/Child Support

- ◯ Weekly
- ◯ Monthly
- ◯ Yearly

G. Other Monetary Support

◯ Weekly
◯ Monthly
◯ Yearly

H. Pension Payments

◯ Weekly
◯ Monthly
◯ Yearly

I. Dividends/Interest

◯ Weekly
◯ Monthly
◯ Yearly

J. Rental Income

◯ Weekly
◯ Monthly
◯ Yearly

K. Net Business Income (self employed/verified by independent sources)

◯ Weekly
◯ Monthly
◯ Yearly

L. Other (strike benefits, training stipends, military family allotment, income from estates and trusts)

◯ Weekly
◯ Monthly
◯ Yearly

Total

◯ Weekly
◯ Monthly
◯ Yearly

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 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 charges in status regards to my income or assets.

Signature of Patient or Guarantor

Date

AUTHORIZATION FOR THE RELEASE OF RECORDS AND INFORMATION

Name

Address

Social Security Number

Birth Date

I,

herby authorize you to release to St. Joseph's Healthcare System any information that may be desired concerning my age, residence, citizenship, employment, income, assets, bank accounts (bank statements).

It is understood that the information obtained will be only used for the purpose directly related to eligibility for Social Security programs, Medicaid, and New Jersey Hospital Care Assistance Program

This Release is made voluntarily and with full understanding.

Signature

Date

CHARITY CARE CHECKLIST
ADDITIONAL DOCUMENATATION REQUIRED

Date

Patient Name

Account #

D.O.S.

In order for St. Joseph's Healthcare System to process your Charity Care Application, the State of New Jersey requires the following Documents.

Identification for:

- ◯ Driver's License
- ◯ Passport
- ◯ Birth Certificate
- ◯ County ID
- ◯ Social Security Card
- ◯ Employee ID Card

Residency From (date)

- ◯ Utility Bill
- ◯ NJ Driver's License
- ◯ Statement of Support
- ◯ Copy of Lease
- ◯ Letter from Landlord

Income From (date)

- ◯ Paystubs immediately prior to date of services (TWO CONSECUTIVE PAYSTUBS)
- ◯ Letter from employer typed on letterhead indicating gross income, pay frequency and hire date
- ◯ Social Security Award Letter
- ◯ Pension Award Letter
- ◯ Unemployment stubs including the extra $50/Disability Award Letter
- ◯ Statement of Support
- ◯ City Welfare Verification Letter
- ◯ Profit and Loss Statement from a certified public accountant on their letterhead

Assets From (date)

- ◯ Stocks/Bonds/CDs/IRAs
- ◯ Cash
- ◯ 401K
- ◯ Checking/Savings Acct of last thirty days

*** ALL BANK PRINT OUTS MUST BE STAMPED AND SIGNED BY BANK ***

STATEMENT IN SUPPORT OF CHARITY CARE APPLICATION

Patient Name	
Account Number	
Date of Service	
To Whom It May Concern	
Patient Signature	
Printed Name	
Date	
Spouse/Supporter/Other Signature	
Printed Name	
Date	