Saint Michael's Medical Center

New Jersey Hospital Care Payment 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 1 - Personal Information MR#

1. PATIENT NAME			2. SOCIAL SECURITY NUMBER
(Last)	(First)	(MI)	

3. DATE OF APPLICATION	4. INITIAL DATE OF SERVICE	5. REQUESTED DATE OF SERVICE
Month Day Year	Month Day Year	Month Day Year

6. STREET ADDRESS OF PATIENT	7. TELEPHONE NUMBER
8. CITY, STATE, ZIP CODE	9. FAMILY SIZE*

10. U.S. CITIZENSHIP	11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ
☐ YES ☐ NO ☐ Pending Application	☐ Yes ☐ No
12. NAME OF GUARANTOR (If other than patient)	13. IS PT OVER 65 YEARS OLD?
	☐ Yes ☐ No ☐ CWF Included

14. IS PT COVERED BY INSURANCE? ☐ Yes ☑ No

SECTION II - Assets Criteria

15. Individual Assets : _____

16. Family Assets : _____

17. 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 _____

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

Reviewed 12-2012

APPLICATION FOR PARTICIPATION (CONTINUED)

SECTION III - INCOME CRITERIA MR#

When determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult; parent'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 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

18. SOURCES OF INCOME

		Weekly	Monthly	Yearly
A. Salary/ Wages Before Deductions		☐	☐	☐
B. Public Assistance		☐	☐	☐
C. Social Security Benefits/Disability		☐	☐	☐
D. Unemployment & Workmen's Compensation		☐	☐	☐
E. Veteran's Benefits		☐	☐	☐
F. Alimony/ Child Support		☐	☐	☐
G. Other Monetary Support		☐	☐	☐
H. Pension 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)		☐	☐	☐
N. 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 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 changes in status to my income or assets.

16. Signature of Patient or Guarantor 17. Date

X