Charity Care Application Instructions

You may apply for Financial Assistance up to 2 years after your Date of Service for inpatient or outpatient services.

Charity Care is available to New Jersey residents who are uninsured, underinsured, or ineligible for state and federal programs. You will be screened to determine if you are eligible for the State of NJ Medicaid program (NJ FamilyCare).

To qualify you must meet both the income and assets eligibility criteria.

Charity Care covers hospital care only. The program does not apply to physicians or other providers who independently bill for their services.

- Please complete and sign the New Jersey Hospital Care Assistance Program application. Return the application to the address below.
- Attach copies of all required documents.
- All documentation is based on the date of service. If you are applying for a future date of service, please use today's date as the Date of Service.
- If you are 21 years of age or younger and a full time college student, your parent or guardian must fill out the application and provide the necessary supporting documents.
- To schedule an interview with a Financial Assistance Counselor at one of Meridian's hospitals, please call (732)212-6505. We can assist you with the Health Insurance Marketplace, NJ FamilyCare and State of NJ Charity Care applications.
- If you have questions, please call 732-902-7080. Financial Assistance Counselors are available Monday to Friday from 8am to 4pm.

Please send the completed application and all documents to:

Meridian Health
Financial Assistance
1945 State Route 33
Neptune, NJ 07753-9986

State of NJ Charity Care
Documentation Requirements

Below is a list of documents used to determine eligibility for Charity Care. Please only provide copies of the documents listed below which apply to your situation. The date of the documents should match the date you were in the hospital. If you are applying for a future date of service, please use today's date as your Date of Service. If we do not receive the appropriate documentation, this may result in your application being denied.

- Insurance Cards: for patient, spouse and/or children. Please copy front and back of insurance cards.

- Personal ID for patient, spouse, children under 18, and/or full time college students 21 and under.
  - Provide one of the following for each member of your family: Driver's License, Birth Certificate, Social Security Card or Passport

- Bank statements (all pages) that shows the balance on the Date of Service.
  - Include all checking, savings and debit card at statements
  - Deposits over your reported income may require an explanation

- Value of and CD's, IRA's, 401K's, Trust Funds, Stocks or Bonds as of the date of service.

- Proof of Income from 1 month prior to the Date of Service.
  - Proof of income, including pay stubs or a letter from your employer on company letterhead stating your **gross** income and date of hire.
  - If you are self-employed, a one or three month profit and loss statement and your last tax return are required.
  - Proof of unearned income including; unemployment, social security award letter, retirement pension, child support, alimony, SSI award letter (for all family members), worker's compensation, State disability, VA benefits, monetary assistance from family members or friends.
  - Complete copy of your tax return for the previous year or a signed affidavit of non-filing.
  - For full time students, you will need to provide all college financial assistance, grants or scholarships you have received for the last year.

- Proof of residency prior to the Date of Service. Must show street address – **NOT** a PO Box.
  - Please provide one of the following that contains your current NJ address, dated prior to the date of service: Driver's License, copy of lease, utility bill or letter of support

- Patient's Attestation: (sign and date all that apply)

- Spouse's Attestation: (sign and date all that apply)

- Letter of Support: to be completed and signed by the person with whom you reside or is helping to support you, other than a spouse

- Marriage Certificate or Divorce Papers

New Jersey Hospital Care Assistance Program
APPLICATION FOR PARTICIPATION

Please indicate the hospital you are applying for:

( )JERSEY SHORE MEDICAL ( )OCEAN MEDICAL ( )RIVERVIEW MEDICAL ( )BAYSHORE ( )SOUTHERN OCEAN MEDICAL

SECTION I – PERSONAL INFORMATION

1. PATIENT NAME (LAST, FIRST, M.I.)			2. SOCIAL SECURITY NUMBER
3. DATE OF APPLICATION	4. DATE OF SERVICE		4A. DATE OF BIRTH
5. STREET ADDRESS OF PATIENT			6. TELEPHONE/CELL NUMBER ( )
7. CITY, STATE, ZIP CODE		8. FAMILY SIZE	MARITAL STATUS

9. US CITIZENSHIP ☐ YES ☐ NO ☐ PENDING APPLICATION	10. PROOF OF N.J. RESIDENCY ☐ YES ☐ NO ☐ EMERGENCY SERVICES
11. NAME OF GUARANTOR (If other than Patient)	12. INSURANCE COVERAGE: ☐ YES ☐ NO NAME: POLICY #:

13: OTHER FAMILY MEMBERS	RELATIONSHIP	SOCIAL SECURITY	BIRTHDATES	NOT COVERED BY CHARITY -REASON
1.				
2.				
3.				
4.				
5.				
6.				

SECTION II- ASSET CRITERIA

14. ASSETS INCLUDE:

A. Savings Accounts _____

B. Checking Accounts _____

C. Certificates of Deposit / IRA _____

D. Equity in Real Estate (other than primary residency) _____

E. Other Assets, 401K, Stocks and Bonds _____

F. TOTAL _____

* FAMILY SIZE INCLUDES SELF, SPOUSE AND ANY MINOR CHILDREN. A PREGNANT WOMAN IS COUNTED AS TWO FAMILY MEMBERS

SECTION III- INCOME CRITERIA

When determining eligibility for hospital care assistance, a spouse's income and credits must be used for an adult parent's(s) Income and credits 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, one month or one week of income prior to the date of service.

EMPLOYER NAME:	TOTAL INCOME $

SOURCES OF INCOME:		Weekly	Monthly	Yearly
A. Salary / Wages before Deductions	_____	☐	☐	☐
B. Public Assistance	_____	☐	☐	☐
C. Social Security/Disability Benefits	_____	☐	☐	☐
D. Unemployment & Workman's Comp.	_____	☐	☐	☐
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	_____	☐	☐	☐
M. Other (Strike benefits, training stipends, Military family allotment, estates or trust)	_____	☐	☐	☐

Other source of income: _____

SECTION IV – CERTIFIED 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 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 status, 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.

SIGNATURE OF PATIENT OR GUARDIAN	**DATE**

FOR OFFICE USE ONLY: Responsibility No insurance coverage _____ %

After insurance coverage_____ %

DATE APPROVED: _____ Effective: _____ Terminates: _____

Evaluator's Signature: _____

PATIENT ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION:

1. I attest that as of _____ I have NOT received any income.
DATE

_____ _____
(Patient / Responsible Party) Relationship DATE

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

_____ _____
(Patient / Responsible Party) Relationship DATE

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

_____ _____
(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/RESPONSIBILITY 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

SPOUSE ATTESTATION

SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION:

1. I attest that as of _____ I have NOT received any income.
DATE

_____ _____
(Spouse / Responsible Party) Relationship DATE

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

_____ _____
(Spouse / Responsible Party) Relationship DATE

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

_____ _____
(Spouse / 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.

_____ _____
(Spouse / Responsible Party) Relationship DATE

RESIDENCY ATTESTATION MUST BE SIGNED BY THE PATIENT/RESPONSIBILITY 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) Relationship 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) Relationship DATE

_____
Interviewer

LETTER OF SUPPORT / ASSISTANCE

PATIENT: DATE:

BIRTHDATE: INITIAL DATE OF SERVICE:

TO BE COMPLETED BY PERSON WHO IS PROVIDING SUPPORT TO THE PATIENT. DOES NOT INCLUDE A SPOUSE 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 Meridian Health may take any legal action appropriate. I further understand that I will personally held responsible if information is falsified, incomplete, or in any way misleading.

Check below whatever applies:

- ☐ The above named person lives with me, and has since **(Date):** _____
- ☐ The above named person was a N.J. resident at the time of the service, has no residency in any other state or country and intends to remain in the state.
- ☐ The above named person is not covered by any type of medical insurance including Medicaid or Medicare.
- ☐ The above named person is unemployed at this time and has been for at least one month prior to the date of service indicated above.
- ☐ The above named person does not receive unemployment benefits or any other type of benefits, such as Disability, SSI, Welfare, etc.
- ☐ I am providing Food and Shelter for the above named person.
- ☐ I am providing Cash in the amount of $_____per month, to the above name person.
- ☐ The above named person does not live with me but I provide support in the form of:

_____.

_____

Signature Your relationship to the above named

Address: _____

_____

Phone Number: _____