



St Lukes Warren Campus  
185 Roseberry Street  
Phillipsburg, NJ 08865  
(908) 847-6828  
(908) 859-6844

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**NJ HOSPITAL CARE ASSISTANCE PROGRAM APPLICATION COMPLIANCE LIST**

**IDENTIFICATION**

- **PATIENT AND LEGAL SPOUSE**
  - a) **One of the following:** Driver License, Motor Vehicle, Social Security Card, Resident Alien, Voters Registration, Medicare, Employee ID; Birth Certificate, Passport. Also Marriage Certificate (**If wife does not have your last name**)
- **MINORS IN HOUSEHOLD (Up to 22 years old if a Full Time Student)**
  - b) **One of the following for each minor:** Student ID, Motor Vehicle, Social Security Card, Resident Alien; Birth Certificate or Passport
- **SUPPORTER**
  - c) Any of the forms listed above on A

**RESIDENCY**

- **PATIENT AND LEGAL SPOUSE**
  - a) A patient's valid NJ Driver's License (**w/current address on it**), Apartment Lease, Telephone Bill (**w/address on it**), Cable or Utility (PSE&G) bill for the **current** or **previous** month when the service was performed or a Stamped PSE&G Printout (\_\_\_\_/\_\_\_\_/\_\_\_\_ or \_\_\_\_/\_\_\_\_/\_\_\_\_), Deed of Property
  - b) A letter or signature from the Landlord or person who you are staying with (**must include: date, how long you live there and your address, signed by him/her with phone number**)
- **SUPPORTER**
  - c) A letter or signature from the person who is helping you (**must include anything listed on A**)

**INCOME**

- **PATIENT AND LEGAL SPOUSE**
  - Copies of the last four (4) pay stubs from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ or two (2) pay stubs for \_\_\_\_/\_\_\_\_/\_\_\_\_ and \_\_\_\_/\_\_\_\_/\_\_\_\_ if you get pay bi-weekly
  - A Company Letterhead indicating how long you've been working there and the weekly gross income. (**Must be signed, titled and dated at least four (4) days before coming to apply**) (See attached sample)
  - Copies of the last two (2) unemployment/disability stubs from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ or a printout report for \_\_\_\_/\_\_\_\_/\_\_\_\_
  - Social Security Award Letter and/or Pension stub from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
  - If self-employed, a Profit and Loss Statement from an accountant for the past three (3) months from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ (See attached sample)
  - A notarized letter from a Public Accountant (See attached sample)
  - Income Tax papers for \_\_\_\_ (If the service date falls between **12/01** and/or **1/31**), they must be signed by the preparer's tax person, yourself and/or legal spouse
  - Other sources of income like: Child Support Letter or Printout, Welfare Package G/H, Annuities, Alimony, etc ...

**ASSETS**

- **PATIENT AND LEGAL SPOUSE**
  - Copy of the Checking/Savings Account or Passbook for the months of \_\_\_\_/\_\_\_\_ and \_\_\_\_/\_\_\_\_
  - A bank letterhead stating the balance on the account for the service date of \_\_\_\_/\_\_\_\_/\_\_\_\_
  - A Stamped Printout Report for the past fifteen (15) days  
(**Letter or report must be dated at least three (3) days before coming to apply**)
  - Copies of the statements of 401 K Plans, Dividends, Stocks, I.R.A., Certificate of Deposits, etc, etc... for \_\_\_\_/\_\_\_\_

PLEASE ACQUIRE THE DOCUMENTS LISTED ABOVE AND APPLY FOR THE NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM  
IN OUR DEPARTMENT LOCATED AT:  
(MATTHEW GEORGE & NAOMI PANTOJA)  
185 ROSEBERRY STREET  
PHILLIPSBURG, NJ 08865  
Monday– Friday 8:00 AM to 4:00 PM  
Phone # (908) 847-6828  
Fax # (908) 847-6039 (English and/or Spanish)

**PS: PLEASE BRING DOCUMENTS GIVEN BACK TO YOU AND REPORT TO THE MAIN LOBBY AND FOLLOW INSTRUCTIONS. THANKS.**



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**AFFIDAVIT OF FACTS**

Acct # \_\_\_\_\_ MR # \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Service: \_\_\_/\_\_\_/\_\_\_

Guarantor: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

1. I have resided at: \_\_\_\_\_  
Address City State Zip Code

Since: \_\_\_/\_\_\_/\_\_\_ In addition, I intend to remain a resident of New Jersey. CITIZEN?  YES  NO

2. At the time of service, I was: \_\_\_\_\_ Company Name: \_\_\_\_\_

Unemployed Pt. Earning/collecting: \$ \_\_\_\_\_  Wk.  Bi/Wk.  Mo.

Collecting Other income received by myself/spouse includes: \$ \_\_\_\_\_  Wk.  Bi/Wk.  Mo.

Retired Source of additional income: \_\_\_\_\_

Employed Source of additional income: \_\_\_\_\_

At the time of service I had no income. I was supported by: \_\_\_\_\_

Relation: \_\_\_\_\_ Address \_\_\_\_\_

3. I am:  Single  Married  Divorced  Widow  Separated

I have \_\_\_ minor child(ren) living with me. \_\_\_\_\_

4.  I/We had no insurance at the time of service.  I/We had no insurance coverage or had limited coverage only through:

Name of Insurance Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_ Subscriber: \_\_\_\_\_

5. On the first date of service, I/We had liquid assets in the amount of: \$ \_\_\_\_\_

Bank: \_\_\_\_\_

At the time of service, I/We had no liquid assets what so ever.

I am making this Affidavit in order to apply for the New Jersey Hospital Care Assistance Program. I'm aware that this assistance is only available for medically necessary hospital care and that costs incurred for Physician services, Anesthesiology services, Radiology interpretation, Outpatient Therapy and Outpatient prescriptions are separate from Hospital charges and may not be eligible for reduction.

By signing this affidavit, I'm certifying that I am who I claim to be. I'm aware, if any of the foregoing statements are false, I'm subject to punishment.

Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_



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New Jersey Hospital Care Assistance Program  
**APPLICATION FOR PARTICIPATION**

**SECTION I - Personal Information**

1. PATENT NAME _____ (Last) (First) (M.I.)		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. CITIZEN SHIP <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> PENDING APPLICATION		11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ <input type="checkbox"/> Yes <input type="checkbox"/> NO
12. NAME OF GUARANTOR (If other than the patient) _____		13. IS PATIENT (SPOUSE, PARENT, OTHER) COVERED BY INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF COMPANY _____ ADDRESS _____

*Eligible Family Members, Including Applicant*

<u>Name</u>	<u>Date of Birth</u>	<u>SS#</u>	<u>Occupation</u>	<u>Monthly Salary</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**SECTION II - Assets Criteria**

14. Individual Assets: \_\_\_\_\_

15. Family Assets: \_\_\_\_\_

16. Assets Include:

- A. Cash \_\_\_\_\_
- B. Saving Accounts \_\_\_\_\_
- C. Checking Accounts \_\_\_\_\_
- 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

# APPLICATION OF 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; parents' 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:

<b>LAST 12 MONTHS</b>	<b>OR</b>	<b>LAST 3 MONTHS X 4</b>	<b>OR</b>	<b>LAST 1 MONTH X 12</b>

### 17. SOURCES OF INCOME

	WEEKLY	MONTHLY	YEARLY
A. Salary/Wages Before Deductions _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Public Assistance _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Social Security Benefits _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Unemployment & Workmen's Compensation _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Veteran's Benefits _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Alimony/Child Support _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Other Monetary Support _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Pension Payments _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Insurance or Annuity Payments _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Dividends/Interest _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Rental Income _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Net Business Income ( self employed/verified by independent source) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Other (strike benefits, training stipends, military family allotment, income from estates and trusts) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Total _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SECTION IV - Certification of 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 government 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.

18. SIGNATURE OF PATIENT OR GUARANTOR

19. DATE

## ATTESTATION FOR PATIENT/SPOUSE/GUARANTOR

1. I attest that I have no income and have had no income from: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_.  

<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Patient/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Spouse/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
  
2. I attest that I have no assets, as listed on my New Jersey Hospital Care Assistance Application through myself or any other Party.  

<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Patient/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Spouse/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
  
3. I attest that I have been separated and have not lived with my spouse since \_\_\_\_\_, do not own any real estate together, have not filed taxes together since \_\_\_\_\_, and do not receive any child support or any financial support whatsoever.  

<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Patient/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
  
4. I attest that I have no medical coverage through myself or any other party to cover this outstanding bill.  

<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Patient/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Spouse/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
  
5. I affirm that all the information given on this worksheet is true to the best of my knowledge.  

<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Patient/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>
<input checked="" type="checkbox"/> _____	_____	___/___/___
<b>Spouse/Responsible Party Signature</b>	<b>Relationship</b>	<b>Date</b>

\_\_\_\_\_  
**Interviewer's Initials**

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**AFFIDAVIT OF FACT**  
**NEW JERSEY HOSPITAL CARE ASSISTANCE APPLICATION**  
**(DECLARACIÓN DE HECHOS)**  
**(APLICACIÓN DE ASISTENCIA MÉDICA HOSPITALES DE NEW JERSEY)**

\_\_\_\_\_  
Patient Name (*Nombre Paciente*)

\_\_\_\_\_  
Account Number (*Número de Cuenta*)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (*Fecha*)

To Whom It May Concern:  
(*A Quién Pueda Interesar*)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: X \_\_\_\_\_  
(*Firma Paciente*)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(*Fecha*)

Patient Name (Print): \_\_\_\_\_  
(*Nombre Imprimido*)

Spouse/Supporter/Other Signature: \_\_\_\_\_  
(*Firma Cónyuge/Ayudador/Otro*)

Spouse/Supporter/Other Name (Print): \_\_\_\_\_  
(*Nombre Imprimido Cónyuge/Ayudador/Otro*)