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

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 AQUIRE 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.

St Luke's Warren Campus
185 Roseberry St.
Phillipsburg, N.J. 08865
(908) 847-6828

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

☐ Retired Other income received by myself/spouse includes: $_____ ☐ Wk. ☐ Bi/Wk. ☐ Mo.

☐ 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

St Luke's WARREN CAMPUS

185 Roseberry St.
Phillipsburg, N.J. 08865
(908) 847-6828

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 ☐ Yes ☐ NO ☐ PENDING APPLICATION	11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ ☐ Yes ☐ NO	
12. NAME OF GUARANTOR (If other than the patient)	13. IS PATIENT (SPOUSE, PARENT, OTHER) COVERED BY INSURANCE ☐ YES ☐ NO NAME OF COMPANY _____ ADDRESS _____	

Eligible Family Members, Including Applicant

Name	Date of Birth	SS#	Occupation	Monthly Salary

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:

LAST 12 MONTHS	OR	LAST 3 MONTHS X 4	OR	LAST 1 MONTH X 12

17. SOURCES 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 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 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

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ATTESTATION FOR PATIENT/SPOUSE/GUARANTOR

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

X_____ _____ _____/_____/_____
Patient/Responsible Party Signature **Relationship** **Date**

X_____ _____ _____/_____/_____
Spouse/Responsible Party Signature **Relationship** **Date**

2. I attest that I have no assets, as listed on my New Jersey Hospital Care Assistance Application through myself or any other Party.

X_____ _____ _____/_____/_____
Patient/Responsible Party Signature **Relationship** **Date**

X_____ _____ _____/_____/_____
Spouse/Responsible Party Signature **Relationship** **Date**

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.

X_____ _____ _____/_____/_____
Patient/Responsible Party Signature **Relationship** **Date**

4. I attest that I have no medical coverage through myself or any other party to cover this outstanding bill.

X_____ _____ _____/_____/_____
Patient/Responsible Party Signature **Relationship** **Date**

X_____ _____ _____/_____/_____
Spouse/Responsible Party Signature **Relationship** **Date**

5. I affirm that all the information given on this worksheet is true to the best of my knowledge.

X_____ _____ _____/_____/_____
Patient/Responsible Party Signature **Relationship** **Date**

X_____ _____ _____/_____/_____
Spouse/Responsible Party Signature **Relationship** **Date**

_____
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_____ Date: _____/_____/_____
(*Firma Paciente*) (*Fecha*)

Patient Name (Print): _____
(*Nombre Imprimido*)

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

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

01/2026

#111 Attachment Appendix C – Application – Pennsylvania Facilities



FINANCIAL ASSISTANCE APPLICATION

Medical Record _____ **Telephone** _____

Patient _____ **Employer** _____

Street _____

City, State, Zip _____

Please list total household income.

	Last 12 Months	Last 3 Months
Gross Income		
Other Family Income		
Total Family Income		
Assets-Savings/ IRA/ CD		
Real estate/ Money Market/ Stocks		

Dependents: (Total of people living in household)

	Name	Age	Relationship
1			
2			
3			
4			
5			

I certify that the above information is complete and accurate to the best of my knowledge. Further, I will cooperate with St. Luke's if deemed necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge.

I understand that this application is made so the hospital can determine my eligibility for uncompensated service under the Financial Assistance Program, based on the established criteria on file in the hospital. If any information I have given proves to be incomplete, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

I authorize my bank, loan institution, insurance company, employer, or any creditor whatsoever of the undersigned to release any information requested by St Luke's Hospital pertaining to any and all financial matter involving or related to the undersigned.

Date **Applicant's Signature**

I understand any physician charges related to my services at St. Luke's Hospital are not covered by this program.

01/2026