New Jersey Hospital Care 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 I - Personal Information

1. PATIENT NAME		2.SOCIAL SECURITY NUMBER
(Last) (First) (MI)		
3. DATE OF APPLICATION	4. INITIAL DATE OF SERVICE	5.REQUESTED DATE OF SERVICE
6. STREET ADDRESS		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	

12. NAME OF GUARANTOR (if other than patient)

SECTION II - Assets Criteria

13. Individual Assets: _____

14. Family Assets: _____

15. Assets Include:

A. Cash _____

B. Savings Accounts _____

C. Checking Accounts _____

D. Certificates of Deposit / I.R.A. _____

E. Equity in Real Estate (other than primary reside _____

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 FOR 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;
parent's(s') income and assets must e 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	LAST 3 MONTHS X 4	LAST 1 MONTH X 12

16. SOURCES OF INCOME

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 and Annuity payments _____

J. Dividends/ Interest _____

K. Rental Income _____

L. Net Business Income (self employed/
verified by indepentent source) _____

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 privatee medical assistance for payment of the hospital bill.
i certify that the above information regarding 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 or assets.

17. SIGNATURE OF PATIENT OR GUARANTOR	18. DATE

AtlantiCare
REGIONAL MEDICAL CENTER

PATIENT NAME: _____

ACCOUNT #: _____

PLEASE **INITIAL** LINE IN FRONT OF EACH STATEMENT THAT APPLIES.

_____ I ATTEST THAT I HAVE NO INCOME AND HAVE NO INCOME SINCE

_____ I ATTEST THAT I HAVE NO ASSETS, INCLUDING BANK ACCOUNT, THROUGH MYSELF OR ANY OTHER PARTY.

_____ I ATTEST THAT I AM HOMELESS AND HAVE BEEN HOMELESS SINCE

_____

_____ I ATTEST THAT I HAVE NO MEDICAL COVERAGE THROUGH MY SELF OR ANY PARTY TO COVER THE OUTSTANDING AMOUNT OF THIS BILL.

_____ I ATTEST THAT I AM A RESIDENT OF THE STATE OF NEW JERSEY AND I HAVE BEEN A RESIDENT OF THIS STATE SINCE

_____

_____ I ATTEST THAT I DO NOT POSSESS ANY MEANS OF IDENTIFICATION.

I AFFIRM THAT ALL INFORMATION GIVEN ON THIS WORKSHEET IS TRUE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.

X _____

SIGNATURE RELATIONSHIP DATE

_____

INTERVIEWER SIGNATURE DATE

AtlantiCare
REGIONAL MEDICAL CENTER

To Whom it May Concern:

I the undersigned _____ (relation to patient) _____

provide the necessary room, board and other life essentials for _____

at my residence _____

and have been doing so from: _____

I am not responsible nor able to pay for any hospital or other expenses for him / her.

Signed: _____ Date: _____

Telephone: _____

Jimmie Leeds Road, Pomona, N.J. 08240 (609) 652-1000
1925 Pacific Avenue, Atlantic City, N.J. 08401 (609) 344-4081

AtlantiCare

REGIONAL MEDICAL CENTER

AUTHORIZATION FOR INFORMATION

ACCOUNT NO. _____

NAME: _____

ADDRESS: _____

_____

SOCIAL SECURITY NO: _____

I do hereby authorized and request the disclosure to AtlantiCare Regional Medical Center any information from social security administration, county social services, banks, or any other source that may be required concerning my age, residence, citizenship, employment, income resource, and any social security benefits. It is understood that the information obtained de used for purpose directly related to my eligibility for the NJ Hospital Care Assistance Program or Medicaid.

_____ **X** _____

DATE SIGNATURE

_____ _____

DATE WITNESSED OR RECEIVED ATLATICARE REGIONAL MEDICAL CENTER REPRESENTATIVE