

**UNIVERSITY MEDICAL CENTER OF PRINCETON AT PLAINSBORO  
NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM**

**REQUIREMENT LIST**

To further assist us in processing your application for Charity Care, please provide copies of the documents listed below which pertain to your financial situation at the time of service. In addition to the signed application, you must include all of the following documentation for all siblings in the family size (this includes spouse and children only). If income is involved, you have a choice of providing 4 weeks, 13 weeks or 12 months prior to date of service. Also include your most recent Federal income tax returns.

Please be advised that any incomplete documentation or final eligibility determination from other programs will delay the application process and require Princeton HealthCare System (PHCS) to deny your application until the appropriate documentation is received.

**Insurance Card: both front and back**

**Identification: Need to provide identification for all family members in the household. May provide one of the following documents for each family member:** Valid driver's license, U.S. resident alien card (green card), passport or visa, social security card or birth certificate.

**Proof of Residency in New Jersey Prior to Your Date of Service: May provide one of the following documents – PO BOX not acceptable.**

Copy of driver's license, utility bill with your name/address for date of service, lease/deed, letter of support attached needs to be notarized from person who you live with/also a copy of his/her driver's license or utility bill attached, or dated mail with your name and address issued prior to date of service.

**Assets: Must provide assets for all family siblings in the household.**

Copies of bank statements showing balance as of date of service. If the statement is a printout, have it stamped and signed by the financial institution representative. This includes checking account, savings account, debit card account statements, CDs, IRA, retirement funds, stocks and bonds, equity in real estate (**other than primary residence**). If you have more than one property besides your primary residence it will be considered an asset. Deposits over your reported income may require an explanation.

**Proof of Income - Employed Applicant:**

Consecutive pay stubs or a letter from the employer verifying gross income, statements written by employer if wage earned is paid in cash, if no letterhead is available from employer, must provide letter with name, address and phone number or business card attached. Proof of unearned income, including but not limited to retirement pension, child support, alimony, VA benefits, Social Security Award letter, SSI Award letters for all family members, unemployment or State Disability record or other financial contributions. Complete copy of your tax return for last year.

**Proof of Income – Self-Employed Applicant:**

If you are self-employed, you must provide a statement from a certified public accountant verifying your gross income, including a list of expenses, then net income. (The same information is required for those who had a loss in their business net income total and explanation of how supporting yourself/family if no income.) If no accountant and tax returns are self-prepared, please request a transcript from IRS.

**Attestation Documents:**

Attestation Document - Patient must sign and date all that apply.

Spouse's Attestation Document - Spouse must sign and date all that apply.

Letter of Support - must be signed by the person with whom you reside (other than a spouse) that is helping to support you.

**Should you have any questions regarding eligibility requirements, please contact the PHCS Financial Counselor at 609-853-7852.**

**Please mail your completed application and supporting documents to:**

**UMCPP's Patient Access Services, Financial Counselor, One Plainsboro Road, Office #T1144, Plainsboro, New Jersey 08536;**

**Or deliver in person to the Financial Counselor, Patient Access Services, located near the Atrium on the first floor or at 609-853-7852, Monday through Friday from 7:30 AM to 4:00 PM.**

# 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

<b>1. PATIENT NAME</b> _____ <small>(LAST) (FIRST) (MI)</small>		<b>2. SOCIAL SECURITY NUMBER</b> _____ - _____ - _____
<b>3. DATE OF APPLICATION</b> _____ / _____ / _____ <small>Month Day Year</small>	<b>4. INITIAL DATE OF SERVICE</b> _____ / _____ / _____ <small>Month Day Year</small>	<b>5. REQUESTED DATE OF SERVICE</b> _____ / _____ / _____ <small>Month Day Year</small>
<b>6. STREET ADDRESS OF PATIENT</b> _____ _____ _____		<b>7. TELEPHONE NUMBER</b> ( _____ ) _____ - _____
<b>8. CITY, STATE, ZIP CODE</b> _____		<b>9. FAMILY SIZE *</b> _____
<b>10. U.S. CITIZENSHIP</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Application	<b>11. PROOF OF 3 - MONTH RESIDENCY IN THE STATE OF NJ</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>12. NAME OF GUARANTOR (If other than patient)</b> _____		

## 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 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 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 be used for a minor child. *Proof of income must be accompany this application.*

Income is based on 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

#### 16. SOURCE 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 By Application

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 change in status in regards to my income or assets.

17. SIGNATURE OF PATIENT OR GUARANTOR

18. DATE

**NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM**

**PATIENT ATTESTATION**

**SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION**

1. I attest that as of \_\_\_\_\_ I have NOT received any income or filed any income tax returns. DATE

\_\_\_\_\_  
Patient/Responsible Party Relationship DATE

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

\_\_\_\_\_  
Patient/Responsible Party Relationship DATE

3. I attest that I am HOMELESS and have been HOMELESS since \_\_\_\_\_

DATE

\_\_\_\_\_  
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/RESPONSIBLE 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

**NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM**

**SPOUSE ATTESTATION**

**SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION**

1. I attest that as of \_\_\_\_\_ I have NOT received any income or filed any income tax returns. DATE

\_\_\_\_\_  
Spouse/Responsible Party DATE

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

\_\_\_\_\_  
Spouse/Responsible Party DATE

3. I attest that I am HOMELESS and have been HOMELESS since \_\_\_\_\_

DATE

\_\_\_\_\_  
Spouse/Responsible Party 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 DATE

**RESIDENCY ATTESTATION MUST BE SIGNED BY THE SPOUSE/RESPONSIBLE 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 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 DATE

\_\_\_\_\_  
Interviewer

NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM

STATEMENT OF SUPPORT

TO BE COMPLETED BY PERSON WHO IS PROVIDING SUPPORT TO YOU.  
(DOES NOT INCLUDE A HUSBAND/WIFE, 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 Princeton HealthCare System may take any legal action appropriate. I further understand that I will personally be held responsible if information is falsified, incomplete, or in any way misleading.

I, the undersigned \_\_\_\_\_ am the \_\_\_\_\_  
Person supporting patient Relationship to patient

of \_\_\_\_\_ . I recognize him/her and attest that  
Patient

he/she resides/resided with me at the following address \_\_\_\_\_  
\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
Date Date

During that time I provided **food, shelter, and basic necessities.**

I am providing cash in the amount of \$ \_\_\_\_\_ per month to the above named person.

I am in no way responsible for his/her medical bills.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Person supporting patient

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

I may be reached at \_\_\_\_\_ if you have any questions.  
Phone number

**NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM**

**AFFIDAVIT OF SEPARATION**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_

Account Number \_\_\_\_\_ Date of Service \_\_\_\_\_

I hereby depose and state that I have been separated from my spouse since \_\_\_\_\_.  
Since that time we have maintained and resided in separate households. We have no financial ties  
whatsoever.

\_\_\_\_\_ I attest that I have no joint bank accounts with my estranged spouse.

\_\_\_\_\_ I attest we do not share a lease or have joint property.

\_\_\_\_\_ I attest we have not filed a joint income tax return since \_\_\_\_\_.

\_\_\_\_\_ I have attached a copy of my last income tax return.

\_\_\_\_\_ I have not attached a copy of my last income tax return because I have not filed income taxes  
for the following years \_\_\_\_\_.

My reason for not filing income taxes is because \_\_\_\_\_

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

I attest that foregoing information is true and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_