Atlantic Health

Eligibility Checklist

Patient's Name: _____ **HNE:** _____

Date of Service: _____/_____/_____

You are encouraged to apply prior to any appointments.
To process your application, the State of New Jersey requires the following documents:
Please read the checklist and gather the required documents before returning to apply for assistance

Provide proof of identification for: _____
Self, Spouse, Minor Children

☐ NJ Driver's License ☐ Passport ☐ County ID ☐ Health Insurance Card ☐ Voter Registration ☐ Birth Certificate
☐ Social Security Card ☐ Employee ID Card ☐ Green card ☐ work permit card

Proof of New Jersey Residency as of: _____

☐ Utility Bill ☐ Cable Bill ☐ NJ Driver's License ☐ Paystub Immediately prior to DOS ☐ Lease/Rental Agreement ☐ Bank Statement
☐ Address/Landlord Certification ☐ Other_____

Patient proof of income from: _____ to _____ ☐ 4 weeks ☐ 1 month ☐ 3 months ☐ 1 year

Spouse proof of income from: _____ to _____ ☐ 4 weeks ☐ 1 month ☐ 3 months ☐ 1 year

☐ Tax return ***(only if DOS is December or January or mix and match needed)***
☐ Letter from employer on letterhead indicating gross income, frequency, hire date (patient/spouse)
☐ Pension Award Letter (patient/spouse)
☐ Paystubs four weeks prior to date of service (patient/spouse)
☐ Statement of Support
☐ Financial Aid Award Letter/Schedule _____ Semester
☐ Outside/Monetary Support
☐ Profit & Loss Statement from Certified Accountant, signed with PTIN# (patient/spouse)
☐ Detailed letter from tenant (rental income)
☐ Unemployment paystubs / Disability Award letter or payment history printout (patient/spouse)
☐ Proof of Child Support/Alimony (patient/spouse)
☐ Social Security Award Letter Year(s)_____ (patient/spouse)
☐ Other:_____

Provide proof of ALL assets as of: _____

☐ Bank Checking/Savings ☐ Foreign owned assets ☐ 401k/403b Plan Statements ☐ Stocks/Bonds/CD/IRA ☐ Cash ☐ Secondary Home Equity

Other Docs: ☐ Power of Attorney (POA) ☐ Marriage Certificate ☐ Death Certificate

Financial Assistance Phone Hours:
8 AM - 5 PM
Telephone Number: 844-487-3627

Date of interview: _____/_____/_____

Interviewer: _____

Atlantic Health

New Jersey Hospital 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
Last First Initial

2. Social Security Number
___-___-____

3. Date of Application
/ / Month Day Year

4. Initial Date of Service
/ / Month Day Year

5. Date of Birth
/ / Month Day Year

6. Current Address of Patient

7. Telephone Number
( ) -

8. State, Zip Code

9. Family Size*

10. Citizenship
☐ Yes ☐ No ☐ Pending Application

ADDITIONAL FAMILY MEMBERS

11. Name of Guarantor (If different from patient)

SECTION II - Assets Criteria

(Please list the exact dollar amount of the below items as of the date of service in box # 4 above)

12. Individual Assets: _____

13. Family Assets: _____

14. 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.**

Atlantic Health

APPLICATION FOR PARTICIPATION
(Continued)

SECTION III - Income Criteria

Upon determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult patient's income and assets must be used for a minor child. ***Proof of income and assets 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 dale of service (Box #4.)

Patient/Family Gross income equals the lesser of the following:

LAST 12 MONTHS OR 1x12		LAST 3 MONTHS X 4		LAST 4 WEEKS X 13		1 WEEK X 52 or 1 BI-WEEKLY X 26
_____	OR	_____	OR	_____	OR	_____

15. SOURCE OF INCOME:

		WEEKLY	MONTHLY	YEARLY
A Salary / Wages Before Deductions	_____	☐	☐	☐
B. Public Assistance	_____	☐	☐	☐
C. Social Security Benefits	_____	☐	☐	☐
D. Unemployment & Workman's Compensation	_____	☐	☐	☐
E. Veteran's Benefits	_____	☐	☐	☐
F. Alimony I 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 sources)	_____	☐	☐	☐
M. Oher (strike benefits, training stipends, Military family allotment, income from estates and trusts)	_____	☐	☐	☐
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 Local or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

As 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 changes in status in regard to my income or assets.

16. Signature of Patient or Guarantor

17. Date

Atlantic Health

To be completed by the patient

CERTIFICATIONS

___ A. I have (#) _____ minor children.

___ B. I am: Single, Married, Divorced, Widow, Separated and have no financial ties with my spouse.

___ C. I receive no child support/alimony from my former spouse/other.

Signed: _____

___ D. I certify that I have had no income from: ____/____/_____ to ____/____/_____.

Signed: _____

___ E. I certify that I have no assets.

Signed: _____

___ F. I attest that I am homeless and have been since ____/____/_____. I do/ I do not occasionally stay at a local shelter. I do/ I do not have identification.
Name/Address of Shelter: _____

Signed: _____

___ G. I certify that I had no health coverage.

Signed: _____

___ H. I have been a resident of the State of New Jersey since _____. I have no residency in any other state or country and have every intention on continuing my residency in New Jersey.

Signed: _____

___I. I am not a resident of the State of New Jersey. I was admitted into the hospital under emergency circumstances.

Signed: _____

__ J. I am making this Affidavit in order to apply for Charity Care.

I understand that the information which I have submitted is subject to verification by Atlantic Health System and the Federal or State Governments. Willful misrepresentation of these facts will negate the hospitals right to receive reimbursement for any charges not covered by a third-party insurance carrier. If so requested by Atlantic Health System I will apply for government or other medical assistance for payment of the hospital bill if I qualify for assistance. I certified that the information with regard to my income, family size and assets is true and accurate to the best of my knowledge.

Signed: _____ Date: _____

Atlantic Health

If married, to be completed by the spouse.

CERTIFICATIONS

___ A. I have (#) _____ minor children.

___ B. I am: Single, Married, Divorced, Widow, Separated and have no financial ties with my spouse.

___ C. I receive no child support/alimony from my former spouse/other.

Signed: _____

___ D. I certify that I have had no income from: ____/____/_____ to ____/____/_____.

Signed: _____

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___ H. I have been a resident of the State of New Jersey since _____. I have no residency in any other state or country and have every intention on continuing my residency in New Jersey.

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Signed: _____ Date: _____