SHORE MEDICAL CENTER℠
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Eligibility Checklist

Patient's Name: _____ **Medical Record #:** _____

Date of Service: _____/_____/_____ **Account Number:** _____

You are encouraged to apply one week prior to any appointments with proof of appointment and/or referral.

In order to process your application, the State of New Jersey requires the following documents:

Please read checklist and gather required documents before returning to apply for assistance

Provide proof of Identification for: _____

- ☐ Driver's License
- ☐ Passport
- ☐ County ID
- ☐ Health Insurance Card
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Employee ID card
- ☐ Death Certificate
- ☐ Marriage Certificate
- ☐ Power of Attorney
- ☐ Other _____

Provide proof of Residency as of: _____

- ☐ Utility Bill
- ☐ Statement of Support
- ☐ NJ Driver's License
- ☐ Other _____
- ☐ Lease/Rental agreement
- ☐ Address Certification or Landlord Attestation (Provided)

Provide proof of Income from: _____ to _____

- ☐ Paystubs immediately prior to date of service
- ☐ Letter from employer on letterhead indicating gross income, frequency, hire date, Medical/Dental insurance and/or 401K details.
- ☐ Unemployment stubs/ Disability Award letter or stamped printout
- ☐ Statement of Support (Provided by representative)
- ☐ Profit & Loss statement from Accountant on letterhead. (Must be signed)
- ☐ Proof of Child Support/Alimony
- ☐ Financial Aid Award letter/schedule_____Semester
- ☐ Detailed letter from tenant(s)
- ☐ Pension Award letter
- ☐ Social Security Award letter Year(s): _____
- ☐ Proof of monetary support

Provide proof of ALL resources as of: _____

- ☐ Bank Statements
- ☐ Foreign owned assets
- ☐ 401K Plan Statements
- ☐ Stocks/Bonds/CD/IRA
- ☐ Life Insurance Policy cash value
- ☐ Cash

Financial Assistance Office Hours and Location

100 Medical Center Way
Somers Point, NJ 08244
(609) 653-3717 Option 1
Hours: Mon.-Fri.
9am – 4:30pm (closed 12pm - 1pm)
Please Call For Appointment

Date of Interview: _____/_____/_____

Interviewer: _____

Follow up representative: _____

Telephone Number: _____

Fax Number: _____

New Jersey Hospital Care Payment 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) (MI)

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.CITIZENSHIP

☐ Yes ☐ No ☐ Pending Application

11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ

☐ Yes ☐ No

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 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 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		Last 3 Months X4		Last 1 Month X12
	or		or	

16. 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. Their 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 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 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

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Patient Primary Attestation

Patient Name: _______ **Account Number: _____**

Date of Service: _____

Please Initial

____ I and/or my spouse attest I/we have no income and have had no income since ___/___/___ to ___/___/___

____ I and/or my spouse attest I have no assets as listed on the charity care application.

____ I and/or my spouse attest I'm homeless and have been homeless since___/___/___

____ I attest I have no Medical Insurance at the time of my admission to the Hospital.

____ I attest that my name is _____. I cannot provide proof of identification because: _____
(State Reason)

_____

____ I and/or my spouse attest I/we have income. Our gross/cash income is $_____ and we get paid on a _____ basis.
Frequency

____ I and/or my spouse attest I have assets on the date of service above for the amount of $_____.

____ I and/or my spouse attest I'm a resident of New Jersey and intend to keep New Jersey as my residence.

____ I attest that I have not made and that I do not intend to make a claim against any third party in which I can seek payment, in whole or in part, for the medical services to which this application relates (including, without limitation, claims for no fault, workers compensation, homeowners, underinsured or uninsured motorist insurance benefits and tort claims). I understand and agree that, if any such claim is made, Shore Medical Center may retract its charity care and seek payment of all charges from me. I also agree to notify Shore Medical Center when a claim is filed.

_____
Patient Signature

_____
Printed Name

_____
Date

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AUTHORIZATION FOR THE RELEASE
OF
MEDICAL RECORDS, FINANCIAL AND DEMOGRAPHIC INFORMATION

Name:_____**D.O.B**._____

Address:_____

Social Security:_____

I_____, hereby authorize you to release to SAVISTA / Shore Medical Center, any information related to my age, residence, citizenship, employment, income, assets and /or bank account statements.

It is understood that the information obtained will be used only for purposes directly related to eligibility for Social Security Programs and Medicaid

This release is made voluntarily and with my full understanding.

Signature:_____ **Date** _____

The information contained in this form is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the recipient, you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address via the U.S. Postal Service.
Thank You.

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Recognition/Statement of Support:

Patient Name: _____ **Account Number:**_____

Date of Service: _____

My name is _____. I certify that I am providing the following type of support and assistance to the above named individual. I recognize the individual to be the patient named above.
I am not responsible, nor able to pay for any hospital or medical expenses for him/her.

From: _____/_____/_____ **to**: _____/_____/_____

	Yes	No		
Food:	☐	☐		
Shelter:	☐	☐		
Cash:	☐	☐	$_____	_____
			Amount	Frequency

I currently reside at the following address: _____

_____

To Whom It May Concern:

_____

_____

_____

_____

_____

_____ _____
Landlord/Supporter Signature **Phone**

_____ _____
Print name **Date**

_____ _____
Patient Signature **Date**