

Hunterdon Medical Center

New Jersey Hospital Care Assistance Program  
Application for Participation

Section I – Personal Information

1. Patient Name

2. Social Security Number

\_\_\_\_\_  
Last

\_\_\_\_\_  
First

\_\_\_\_\_  
MI

3. Date of Application

Initial Date of Service

Location of Initial date of Service

\_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_

4. Mailing address of Patient

\_\_\_\_\_  
Street

\_\_\_\_\_  
Town

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

5. Family Members & Dates of Birth (M/D/Y)

6. Family Size\*

7. Do you have:

Medicare  Yes  No

Insurance  Yes  No

Medicaid  Yes  No

Kid/FamilyCare  Yes  No

8. Telephone Number

(\_\_\_\_) \_\_\_\_\_

9. Proof of NJ Residency

Yes  No

10. Name of Guarantor (if other than patient)

Section II – Assets Criteria

11. Assets Include:

A. Cash

A. \$ \_\_\_\_\_

B. Savings Accounts

B. \$ \_\_\_\_\_

C. Checking Accounts

C. \$ \_\_\_\_\_

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

D. \$ \_\_\_\_\_

E. Equity in Real Estate (other than primary residence)

E. \$ \_\_\_\_\_

F. Other Assets (Treasury Bills, Negotiable Paper, Corporate stocks, & bonds, etc.)

F. \$ \_\_\_\_\_

G. Total Assets

G. \$ \_\_\_\_\_

\*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 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.

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	<u>Last 12 Months</u>	<u>Last 3 Months X4</u>	<u>Last 1 Month X12</u>
<b>12. Sources of Income</b>			
	Amount	Weekly	Bi-weekly
A. Salary/Wages Before Deductions	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
B. Public Assistance	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
C. Social Security Benefits	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
D. Unemployment & Worker's Compensation	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
E. Veteran's Benefits	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
F. Alimony / Child Support	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
G. Other Monetary Support	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
H. Pension Payments	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
I. Insurance or Annuity Payments	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
J. Dividends / Interest	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
K. Rental Income	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
L. Net Business Income (self employed) Verified by independent source	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
M. Other (strike benefits, training stipends, military family allotment, income from estates & trusts)	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Total:</b>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

**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 give Hunterdon Medical Center permission to contact my employer to verify my gross pay or length of employment. I give Hunterdon Medical Center permission to contact my county social services department to determine if my family will qualify for any benefits.

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.

13. Signature of Patient or Guarantor \_\_\_\_\_ 14. Date \_\_\_\_\_



HUNTERDON  
MEDICAL  
CENTER

2100 WESCOTT DRIVE  
FLEMINGTON, NJ 08822  
PHONE 908-788-6100

I attest that I have no medical insurance, Medicare, Medicaid or NJ FamilyCare through myself or any other party to cover any portion of my medical bills.

\_\_\_\_\_  
(Patient/Responsible Party)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Date)

I do have medical coverage, Medicare, Medicaid, or NJ FamilyCare and have included all information needed to submit bills to my insurance. (Either photo copy of insurance ID card or insurance company's name & your ID number written below)

\_\_\_\_\_  
(Patient/Responsible Party)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Date)