SHORE MEDICAL CENTER

CHARITY CARE APPLICATION
REQUIRED DOCUMENTATION CHECK LIST

Please return the items below if they apply to your situation. Theses items are required to process your application for charity care assistance.

Please note that your application will be denied if all documentation is not supplied. Please refrain from using correction fluids.

_____ Federal Income Tax Return (1040, W2, and all schedules that apply)
_____ Pay stubs for a period of 13 weeks prior to date of service _____ to_____
_____ Letter of support, if you have zero income (Attachment B)
_____ Unemployment Benefits: Either the check stubs for 13 weeks or loops printout
_____ VA Pension Benefits Letter for the year prior to your visit
_____ Pension Benefits Letter with stub for the month of your visit
_____ Social Security Benefits Letter for the year prior to your visit
_____ Child support and/or alimony documentation
If child support and/or alimony are through the probation office, please provide your case #_____.
_____ General assistance: Copy of your Medicaid card, letter from your case worker stating when you started receiving, amount, and if the case is still open. (Note: this letter can be provided to you if you need one to take to your case worker.
_____ Bank statements (checking and/or savings) the month of your visit which must reflect a balance on the date of your service.
_____ Any and all assets, which include 401K, stocks, bonds, IRA, and real estate other than your primary residence
_____ One form of identification for all immediate family members that are listed on this application (Example: driver license, birth certificate, or social security card) A boat license is not acceptable
_____ A copy of any and all insurance cards
_____ Proof of New Jersey residency on the date of your service (Example: New Jersey driver license, lease, utility bill, rent receipt.) Your name and address must appear on this document.
_____ Self-employed patient: Please provide a profit & loss statement for the three months prior to your visit. This must be completed by an accountant or local tax service.
_____ other required info _____

*** Please see reverse side for additional information

To speak with a Financial Counselor regarding Charity Care or Medicaid eligibility please call any of the phone numbers below. The following people can be located on the first floor of the hospital.

Name	**Phone Number**	**Fax Number**
Rose Ann Clements	(609) 653-3500 ext 2086	(609) 653-3922
Pat Sutor	(609) 653-3804	(609) 653-3922
Jion Price	(609) 653-3231	(609) 926-4313
Renee Emper	(609) 653-3533	(609) 926-4313

Application can be faxed or mailed.

Mailing address is:

Shore Medical Center:

Attention Credit Department

Name of your representative

1 East New York Ave

P.O. Box 217

Somers Point, N.J. 08244-0217

APPLICATION FOR PARTICIPATION

Proof of Identification, Income and 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

Patient Name (Last, First, MI) _____

Street Address _____

City, State, Zip Code _____

Telephone Number ( ) _____ Date of Application _____
Date of Service_____

Social Security Number _____ - _____ - _____ Requested Date of Service_____

Name of Guarantor (If other than the patient) _____

Family Size** _____

US Citizenship? (Circle One) YES NO APPLICATION PENDING

Proof of New Jersey Residency? (Circle One) YES NO

SECTION II – Assets Criteria

Individual Assets: _____

Family Assets: _____

Assets Include:

Cash	$ _____
Saving Accounts	$ _____
Checking Accounts (Bank or Credit Union)	$ _____
Certificates of Deposits (CD's)/ I.R.A / 401K	$ _____
Equity in Real Estate (Other than Primary residence)	$ _____
Other assets (Treasury bills, Negotiable Paper, Corporate stocks / bonds)	$_____
TOTAL:	$ _____

** Family size includes self, spouse, and any minor children. A pregnant woman is counted as two.

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 and Assets **must** accompany this application.*

Income is based on the calculation of twelve months, three months or one month of income prior to the date of service (whichever is to the applicant's benefit).

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

The last 12 months OR Last 3 months x4 OR Last 3 months x12

Sources of Income

	Weekly	***Monthly***	***Yearly***
Salary/ Wages before Deduction			
Public Assistance			
Social Security Benefits			
Unemployment/ Workers Compensation			
Veteran's Benefits			
Alimony / Child Support			
Other Monetary Support			
Pension Payments			
Dividends / Interest			
Rental Income			
Net Business Income (Self employed needs verification by independent)			
Other (Strike benefits, training stipends, Military family allotment, income from Estates and Trusts)			
TOTAL			

SECTION IV – Certification by Applicant

I understand 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 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.

Signature of Patient or Guarantor _____ **Date** _____

SHORE MEDICAL CENTER FINANCIAL QUESTIONNAIRE

I. ASSETS

Bank Name _____ Branch Location _____

Account Number (Checking) _____ Balance $_____

Account Number (Savings) _____ Balance $_____

Other Assets**

_____ $ _____

_____ $ _____

_____ $ _____

TOTAL ASSETS: $ _____

II. TOTAL NUMBER OF DEPENDENTS (Including yourself) _____

Dependent's Name	*Date of Birth*	*Social Security Number*

Please circle one answer.

Is this service due to a Work or Auto related injury?	NO	YES	
Are you currently pending S.S.I.?	NO	YES	Date filed _____
Is there litigation pending?	NO	YES	

I understand the information which I submit is subject to verification by Shore Medical Center and Federal State governments. Willful misrepresentation of these facts will make me liable for all hospital charges. If so requested by Shore Medical Center, I will apply for government or private assistance for the payment of this hospital bill. I further understand that Shore Medical Center will conduct a credit check with Credit Bureau Associates in order to assist in determining my ability to pay.

I certify that the above information regarding my family size, income and assets is true and correct.

_____ _____

Patient / Guarantor Signature — Date

_____ _____

Spouse / Power of Attorney (Documentation needed) — Date

To whom it may concern:

I/We do hereby authorize and request the disclosure to Shore Medical Center, their agent, representative or bearer to inspect, review, copy including Photostat copies of all records pertaining to my age, residence, citizenship, employment, income, resources, health records and any Social Security Benefits. It is understood that the information obtained be used for purposes directly related to my eligibility for the New Jersey Hospital Care Program (Charity Care) and/or New Jersey Medicaid.

Photostat copies of the authorization will be considered as valid as the original.

_____ _____

Signature of patient/guarantor Date

Hospital Assistance is free or reduced charge care and is provided to patients who receive either inpatient or outpatient services at acute care hospital throughout the state of New Jersey. Hospital assistance and reduced charge care is available only for necessary hospital care and does not cover physicians (Example: Bay front Emergency Physicians, Shore Imaging) or prescription drugs.

_____ _____

Signature of patient/guarantor Date

To Whom It May Concern:

I, _____ attest that I provide(d) the necessary room, board, and other life essentials for _____ at my residence _____ _____ from _____/ _____/ _____ to _____ / _____/ _____ or present.

My relationship to the above patient(s) is that of: _____.

I understand that signing this does not make me financially responsible for any debt and that this form only establishes support.

_____ _____
Signature Date

Telephone Number ( ) _____

Please note: the person signing this attestation must also include a copy of their ID.

SHORE MEDICAL CENTER

PLEASE SIGN ALL APPLICABLE STATEMENTS

☐ I attest that I have no income and have had no income from

_____/_____/_____ to _____/_____/_____.

_____	_____	_____
Signature of Patient/Guarantor	*Spouse/Other*	*Date*

☐ I attest that I have no assets as listed on my Charity Care Application through myself or any other party. This also applies to any minor children in the household.

_____	_____	_____
Signature of Patient/Guarantor	*Spouse/Other*	*Date*

☐ I attest that I am homeless and have been homeless since _____/_____/_____.

_____	_____	_____
Signature of Patient/Guarantor	*Spouse/Other*	*Date*

☐ I attest that I have no medical coverage through myself or any other party to cover the outstanding amount of this bill.

_____	_____	_____
Signature of Patient/Guarantor	*Spouse/Other*	*Date*

☐ I attest that I have not filed any income tax returns for the year(s) of_____ to _____.

_____	_____	_____
Signature of Patient/Guarantor	*Spouse/Other*	*Date*