



CBIZ KA CONSULTING SERVICES

Patient Name:

Account#

Date of Service:

Balance:

Dear Patient,

Per your request the financial screening application is attached. Please complete all the requested information and return it promptly.

This letter is in reference to your pending account for the services rendered while at Trinitas Regional Medical Center. In cooperation with Trinitas Regional Medical Center, we may be able to assist with your unpaid medical bills. Your account has been referred to me in order to determine your eligibility for our various array of assistance programs that may help cover your charges and pending bills at **NO COST TO YOU.**

Please bring with you the following pending documents:

Patient and/or family including children under 18:

- ✓ A valid New Jersey drivers license with current address
- ✓ Expired New Jersey drivers license
- ✓ Passports
- ✓ Resident Alien Card
- ✓ Work Authorization card
- ✓ Social Security Card
- ✓ Marriage Certificate (if you are married)
- ✓ Birth Certificates

Proof of Address: Month of –

- ✓ Cable Bill
- ✓ Gas Bill
- ✓ Electricity Bill
- ✓ Water Bill
- ✓ Lease

Proof of Income:

- ✓ Copies of your last 4 pay stubs if you get paid weekly or last 2 if you get paid bi-weekly
- ✓ If you get paid in cash, a letter from your employer on a company letterhead will be required
- ✓ Unemployment or Disability paystubs
- ✓ Letter of Support

Proof of Assets: Month of -

- ✓ Complete bank statement checking and/or savings-all pages for month stated above
- ✓ Direct express and any other direct deposit banking system
- ✓ Print out from bank with bank stamp and signature from bank representative
- ✓ 401k statements

Address: 210 Williamson St. Elizabeth NJ 07201 or 655 East Jersey St. Basement Elizabeth NJ 07201

**New Jersey Hospital Care Assistance Program
APPLICATION FOR PARTICIPATION**

SECTION I - Personal Information

1. PATENT NAME _____ (Last) _____ (First) _____ (M.I.)		2. 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. CITIZEN SHIP <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> PENDING APPLICATION		11. PROOF OF 3-MONTH RESIDENCY IN THE STATE OF NJ <input type="checkbox"/> Yes <input type="checkbox"/> NO
12. NAME OF GUARANTOR (If other than the patient) _____		13. IS PATIENT (SPOUSE, PARENT, OTHER) COVERED BY INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF COMPANY _____ ADDRESS _____

Eligible Family Members, Including Applicant

Name	Date of Birth	SS#	Occupation	Monthly Salary
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SECTION II - Assets Criteria

14. Individual Assets: _____

15. Family Assets: _____

16. Assets Include:

- A. Cash _____
- B. Saving Accounts _____
- C. Checking Accounts _____
- D. Certificate 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 OF 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; parents' 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	OR	LAST 3 MONTHS X 4	OR	LAST 1 MONTH X 12

17. SOURCES 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 of 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 government 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.

18. SIGNATURE OF PATIENT OR GUARANTOR _____

19. DATE _____

Patient Attestation

Patient Name: _____ Acct Number/MR#: _____
Date of Service: _____

Please Initial

____ I attest that my name is _____.

____ My Marital Status is ____ Single ____ Married ____ Divorced ____ Widowed
____ Separated/No Financial Ties since ____/____/____.

____ I and/or my spouse attest I'm a **Resident of New Jersey** since ____/____/____ residing at
_____ and Intend to Remain.

____ I and/or my spouse attest that I am in the U.S.A as a ____ **Undocumented Alien**
____ **Resident Alien** and Intend to remain as a resident of New Jersey.

____ I and/or my spouse attest that I/we are **Homeless** and have been homeless
Since ____/____/____.

____ I attest that my name is _____, I cannot provide proof of
Identification because: _____

____ I and/or my spouse attest I/we **Have Income**. Our gross/cash income is \$ _____
And we get paid on a _____ basis.

____ I and/or my spouse attest that I/we have **No Income** since ____/____/____ to ____/____/____.
And have been supported by _____ relationship _____.

____ I and/or my spouse attest that I do not receive any **Child Support** since ____/____/____
For my child/children.

____ I and/or my spouse attest I **Have Assets** on the date of service above for the amount of
Checking \$ _____ savings \$ _____ other \$ _____

____ I and/or my spouse attest that I have **No Assets** as listed on the application.

____ I attest I have **No Medical Coverage** through myself or any other party to cover the
Outstanding amount of this bill.

____ My **Family Size** is _____, including myself, spouse and children under age 18 residing in the
Household (pregnant women account as 2 with proof of pregnancy).

____ I attest that all the above information is true and correct.

X _____
Patient Signature

X _____
Date