Bergen New Bridge Medical Center

A Clinical Affiliate of RUTGERS

CHARITY CARE DOCUMENT CHECK LIST

LISTA DE VERIFICACIÓN DE DOCUMENTOS PARA ATENCIÓN DE CARIDAD

Patient Name / Nombre del paciente: _____

D.O.B. / Fecha de nacimiento: _____

Social Security # / N.º de Seguro Social: _____

Identification:

_____ Driver's License / Licencia de conducir
_____ Alien Registration / Registro de extranjero
_____ County ID Card / Tarjeta de ID del condado
_____ Birth Certificate / Certificado de nacimiento
_____ Ins. ID Card / Tarjeta de ID del seguro
_____ Union Membership Card / Tarjeta de membresía al sindicato
_____ Welfare ID / ID de bienestar social
_____ Other / Otro: _____
_____ Passport / Pasaporte
_____ Social Security Card / Tarjeta de Seguro Social
_____ Employer ID / ID del empleador
_____ Homeless Attestation / Certificación de persona sin hogar
_____ Voter Registration Card / Tarjeta de registro de votante
_____ Student ID / ID de estudiante

New Jersey Residency - REQUIRED for applicant only / Residencia de New Jersey: OBLIGATORIO únicamente para el solicitante

_____ Driver's License / Licencia de conducir
_____ Utility bill / Factura de servicios públicos
_____ Other / Otro: _____
_____ County ID w/an address & Issuance date / Identificación del condado con una dirección y fecha de emisión
_____ Mail showing address & Post mark as of d.o.s / Correo que muestra la dirección y matasellos a la fecha del servicio.

I**ncome: Supply information for each family member that has income. / Ingreso: proporcione información para cada miembro de la familia que tenga ingreso.**

_____ 1 month of pay stub subject to d.o.s. / 1 mes de comprobantes de pago sujeto a la fecha del servicio.
_____ Letter of support / Carta de respaldo
_____ SS benefit statement / Declaración de beneficios del SS
_____ Employment Verification / Verificación de empleo
_____ Pension statement / Declaración de pensión
_____ Other / Otro

Assets: Supply information for each family member that has assets. / Activos: proporcione información para cada miembro de la familia que tenga activos.

_____ Attestation of no assets / Certificación de carencia de activos
_____ IRA / IRA
_____ Trust Funds / Fondos de fideicomiso
_____ Checking Statement for d.o.s / Estado de cuenta corriente a la fecha del servicio
_____ Saving Statements for d.o.s. / Estados de cuentas de ahorros a la fecha del servicio
_____ CD / Certificado de depósito
_____ T Bills / Bonos del Tesoro
_____ Stocks & Bonds / Acciones y bonos

Bergen New Bridge Medical Center
230 East Ridgewood Avenue, Paramus, New Jersey 07652
Phone: 201.967.4000
www.newbridgehealth.org

New Jersey Hospital Care Assistance Program
DETERMINATION OF APPLICATION FOR PARTICIPATION

SECTION 1 - Applicant Information

1. Patient Name			2. Family Size
3. Date of Service		4. Date of Determination	5. Date of Expiration
6. Income Computation	☐ 12 Months ☐ 3 Months	☐ 13 Weeks x 4 ☐ 1 Month x 12	7. Total Income

SECTION II - Medicaid Determination

8. Was referral made for Public Assistance

☐ YES ☐ NO Explain: _____

_____

SECTION III - Determination

☐ Your request for New Jersey hospital assistance has been approved. Your financial responsibility is _____ % of the hospital bill for services beginning on _____. The hospital may provide assistance of _____ % of the Hospital charges for any future hospital services for a period of _____ months from the initial date of service.

☐ Your request for New Jersey hospital assistance has been denied because you do not meet the eligibility requirements.
Specific reasons for ineligibility are as follows:

- ☐ Documentation of income not provided. *
- ☐ Documentation of assets not provided. *
- ☐ Income exceeds eligibility criteria.
- ☐ Assets exceed eligibility criteria. **
- ☐ Patient referred to Medicaid.
- ☐ Failure to provide Medicaid denial.
- ☐ Other: _____

_____

*Applicants found ineligible based on the fact that specific information was not provided should direct this information to the Hospital.

Hospital Name and Address: **Bergen New Bridge Medical Center**
230 East Ridgewood Avenue
Paramus, New Jersey 07652-4131

Hospital telephone Number: **CREDIT & COLLECTION DEPARTMENT - 201-967-4114**

** Applicants with assets that exceed eligibility have the option to “spend down” the excess assets toward the hospital bill.
If you pay _____ toward your hospital bill, the remaining balance can be considered eligible for _____ % under the New Jersey Hospital Care Assistant Program.

Name of Evaluator	Title
Signature	Date

Applicants who have questions about the program may contact the

New Jersey State Department of Health
HEALTH CARE FOR THE UNINSURED PROGRAM
CN 360, Trenton, NJ 08625-0360
Telephone Number: 1-866-588-5696

New Jersey State Hospital Care 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 _____ 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. 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 _____
F. Other Assets (Treasury bills, negotiable paper, corporate stocks and bonds) _____

G. **TOTAL:** _____

~ PLEASE COMPLETE PAGE 2 ~

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

APPLICATION FOR PARTICIPATION (CONTINUED) - PAGE 2

SECTION III - Income Criteria

When determining eligibility for hospital care assistance, a spouse's income and assets must be used for an audit; 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. 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

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. Other Monetary Support		☐	☐	☐
H. Pension Payments		☐	☐	☐
I. Insurance or Annuity Payments		☐	☐	☐
J. Dividend/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 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 or assets.

17. Signature of Patient or Guarantor	18. Date

Bergen New Bridge Medical Center

A Clinical Affiliate of RUTGERS

AUTHORIZATION FOR THE RELEASE OF RECORDS AND INFORMATION
AUTORIZACIÓN PARA DIVULGAR LOS EXPEDIENTES Y LA INFORMACIÓN

Name / Nombre: _____ DOB / Fecha de nacimiento: _____

Address / Dirección: _____

Social Security # / N.º de Seguro Social: _____

I / Yo, _____, hereby authorize you to release Adreima/Bergen New Bridge Medical Center any information that may be desired concerning my age, residence, citizenship, employment, income, assets and/or bank account statements. / por el presente autorizo a usted para que divulgue a Adreima/Bergen New Bridge Medical Center cualquier información que pueda solicitarse con relación a mi edad, residencia, ciudadanía, empleo, ingreso, activos y/o estados de cuenta bancarios.

It is understood that the information obtained will be used for purposes directly related to eligibility for the New Jersey State Hospital Care Assistance Program and Medicaid. / Se entiende que la información obtenida se usará para propósitos directamente relacionados con la elegibilidad para el Programa de Asistencia para el cuidado de New Jersey State Hospital y Medicaid.

This release is made voluntarily and with my full understanding. / Esta divulgación se realiza de manera voluntaria y con mi pleno entendimiento.

Signature / Firma: _____ Date / Fecha:_____

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. / La información contenida en este formulario es privilegiada y confidencial, con el único objetivo de que la utilice la persona o entidad mencionada anteriormente. Si el lector de este mensaje no es el destinatario, por el presente se le notifica que está estrictamente prohibida cualquier divulgación, distribución o reproducción de la comunicación.

Bergen New Bridge Medical Center
230 East Ridgewood Avenue • Paramus, New Jersey 07652
201 .967.4000

PATIENT ATTESTATION
CERTIFICACIÓN DEL PACIENTE

Attention: Credit and Collection / **Atención:** Crédito y cobros
Name / Nombre: _____ Date / Fecha: _____
Account # / N.º de cuenta: _____ Date of Service / Fecha del servicio: _____

1. *I attest that I have no income. / Certifico que no tengo ingresos.*
Signature of Patient or Responsible Party / Firma del paciente o Parte responsable: _____
Spouse Signature / Firma del cónyuge: _____

2. *I attest that I have no assets. / Certifico que no poseo activos*
Signature of Patient or Responsible Party / Firma del paciente o Parte responsable: _____
Spouse Signature / Firma del cónyuge: _____

3. *A. I attest that I am homeless and have been since / Certifico que estoy sin hogar y he estado así desd:*
Date / Fecha: _____
B. I attest that I am homeless and have no identification since / Certifico que estoy sin hogar y no poseo identificación desde:
Date / Fecha: _____
C. My last known address was / Mi última dirección conocida fue: _____
_____
Signature of Patient or Responsible Party / Firma del paciente o Parte responsable: _____
Spouse Signature / Firma del cónyuge: _____

4. *I attest that I have no insurance to cover a hospital service. / Certifico que no poseo seguro para cubrir un servicio hospitalario.*
Signature of Patient or Responsible Party / Firma del paciente o Parte responsable:_____
Spouse Signature / Firma del cónyuge: _____

5. *I attest that I have lived in New Jersey for / Certifico que he vivido en New Jersey durante _____ months/year and have the intent to remain in New Jersey. / meses/años y tengo la intención de permanecer en New Jersey.*
My current address in New Jersey is / Mi dirección actual en New Jersey es: _____
_____
Signature of Patient or Responsible Party / Firma del paciente o Parte responsable: _____

6. Do you or your spouse own property in which you do not reside? / ¿Posee usted o su cónyuge alguna propiedad en la que no reside? Yes / Sí _____ No / No _____
If yes, provide mailing address of property / Si respondió sí, proporcione la dirección postal de la propiedad: _____
_____
_____
Patient Signature / Firma del paciente: _____
Spouse Signature / Firma del cónyuge: _____

I certify that this information is true and accurate to the best of my knowledge for the date of service above.
Certifico que esta información es cierta y precisa según mi leal saber y entender
a la fecha del servicio que se indicó anteriormente.

Signature of Patient or Responsible Party / Firma del paciente o Parte responsable: _____

Witness / Testigo: _____

Bergen New Bridge Medical Center

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STATEMENT IN SUPPORT OF NJ HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM APPLICATION

DECLARACIÓN EN APOYO A LA SOLICITUD DEL PROGRAMA DE ASISTENCIA PARA EL PAGO DE ATENCIÓN EN NJ HOSPITAL

Patient Name / Nombre del paciente: _____

Account Number / Número de cuenta: _____

Date of Service / Fecha del servicio: _____

To Whom It May Concern / A quien interese:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Patient Signature / Firma del paciente

_____
Printed Name / Nombre en letra de molde

_____
Date / Fecha

_____
Spouse/Supporter/Other Signature
Cónyuge/Benefactor/Otra firma

_____
Printed Name / Nombre en letra de molde

_____
Date / Fecha

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