Mail to: Sierra Health Group, LLC
440 Franklin Street, Suite 300
Bloomfield, NJ 07003

New Jersey Hospital Care Assistance Program

Fax to: 888-420-7704

APPLICATION FOR PARTICIPATION

PROOF OF IDENTIFICATION, PROOF OF INCOME, AND PROOF OF ASSETS MUS ACCOMPANY THIS APPLICATION.
SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTS, AS THEY <u>WILL NOT</u> BE RETURNED.

SECTION I – Personal Information

1. PATIENT NAME _____ _____ _____ (Last) (First) (MI)		**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 (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 (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. 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 PARENT OR GUARANTOR	18. DATE