CAPE REGIONAL MEDICAL CENTER
UNCOMPENSATED CARE OR REDUCED CHARGE CARE APPLICATION

PATIENT'S NAME: _____
ACCOUNT NUMBER _____ DATE OF SERVICE___/___/___

In order to process your application for Uncompensated Care or Reduced Charge Care, it will be necessary for you to provide the hospital with copies of the following information:

_____ Proof or gross income 4 weeks prior to the date of service. (Page 5)
(___/___/___ to ___/___/___ **(If no income, please contact this office as soon as possible)**
If Self-employed must have Profit and Loss for 13 weeks prior to the date of service.

_____ Proof of liquid assets from (___/___/___ to ___/___/___) (Page 5)
All documents submitted (**Bank print-outs**) must be on the LETTERHEAD or STAMPED and SIGNED by BANK TELLER. All **pages** of **bank statement** must be supplied. (**NO EXCEPTIONS TO THIS RULE)**

_____ Medicaid denial (**If under 19, over 65, pregnant, disabled or no income**)
(Page 3)

_____ Copy of identification (_____). Copies of **insurance cards**
for all family members must also be supplied. (Page 2)

_____ Proof of residency as of the date of service (___/___/___). (Page 2)

_____ Other _____

_____

When you have completed the application, please return it with the required documentation to:

Cape Regional Medical Center
2 Stone Harbor Blvd
Cape May Court House, NJ 08210
Attn: Financial Counseling Department

For help with the application, please call 609-463-2247, 2443, 2441 or 2247.
Fax 609-463-2442

APPLICATIONS WILL NOT BE APPROVED WITHOUT PROPER DOCUMENTATION
See corresponding page for complete description.

CAPE REGIONAL MEDICAL CENTER

IDENTIFICATION

Documentation of identification may include, but is not limited to, a driver's license, a voter's registration card and alien registry card, a birth certificate, and employee identification card, a union membership card, insurance or welfare plan identification care or a Social Security card.

PROOF OF RESIDENCY AS OF THE DATE OF SERVICE.

New Jersey Charity Care guidelines require that a patient be a resident of the State of New Jersey as of the date of service. Proper proof of New Jersey residency includes the following items: any of the identification listed above which contains the applicant's mailing address, a copy of a deed or lease to a property in New Jersey, and article of mail sent to the patient at the New Jersey address, **plus an attestation** that the applicant resided in New Jersey as of the date of service, or a letter from the New Jersey resident with whom the applicant is living stating that the applicant resides with him/her.

PROOF OF GROSS INCOME ***(FOR FAMILY)***

Pay stubs 4 weeks prior to the date of service – if not available, letter from employer on employer's letterhead stating weekly gross wages for the 4 weeks prior to the date of service. (**If NO LETTERHEAD, EMPLOYER MUST SIGN AND VERIFY PAYROLL LETTER OR PRINTOUT**). If self-employed a profit and loss statement by an accountant is required for the quarter prior to service.

Proof of child support, alimony, etc. for the 4 weeks prior to the date of service.
Income tax return for prior year, along with all documents used to file return.
Proof of Social Security, Pensions, Unemployment, etc. for the 4 weeks prior to the date of service. (**If using bank statements as proof of income for pension or SSI benefits we will need 3 months of bank statements.)**

If you have **no income**, you will be required to apply for Public Assistance with the proper agency. **Please call this office as soon as possible.**

PROOF OF ASSESTS ***(FOR FAMILY)*** (**INDIVIDUALS $7500/ FAMILY $15000 MAX**)

Checking account and/or savings account statements with the balance on the date of service, **all pages must be submitted. (Or a print-out from the bank on bank letterhead showing activity for the 30 days prior to the date of service and the balance on the date of service.)**

Certificate of Deposit, IRA, Treasury Bills, Corporate Stocks and Bonds, and Equity in Real Estate, other than the patient's primary residence, are counted as liquid assets. Documentation must be provided as of the date of service.

LETTER OF DENIAL FROM ANY/ALL PUBLIC ASSISTANCE AGENCIES (**If you have no income for a single person or low income for a family**)

YOU MUST SUBMIT COPIES OF INSURANCE CARDS FOR ALL FAMILY MEMBERS. ***(FRONT AND BACK MUST BE SENT)***

NO ASSISTANCE WILL BE GIVEN WITHOUT PROPER DOCUMENTATION

It is very important that you sent the requested information along with your application. You have up to 1 year from the date of service to apply. If you have questions, please call the Financial Counseling Department at (609)463-2443 or (609)463-2247.

CHARITY CARE QUESTIONS FOR PATIENT

Is any family member covered by insurance? ..... Y/N
(If yes, application must include copies of cards)
Are you a NJ resident? ..... Y/N
Are you a US citizen?..... Y/N
Are you pregnant? ...(Please apply for Jersey Care/Medicaid)..... Y/N
Are you under age 19 or over age 65?..... Y/N
(If yes, you must apply for Medicaid)
Did you file for Social Security Disability?..... Y/N
(If yes, what date did you file ___/___/___)
Have you been declared disabled by Social Security?..... Y/N
(If yes, you must provide us with a Medicaid denial)
Have you applied for the Family Care?..... Y/N
(If yes, what date ___/___/___. Have you heard from them yet?_____ ,
what was the outcome:_____

_____.
(Please attach all correspondence)

If you are single, between the ages of 19 and 65, with no income or dependents, you must apply for General Assistance, if you are not eligible please provide a letter to that effect from their office.

PLEASE MARE SURE ALL COPIES ARE CLEAR AND READABLE.

CAPE REGIONAL MEDICAL CENTER

Patient name _____ SSN ___-___-_____

Address _____

City _____ State ____ Zip _____ Phone(___) ___-_____

Birtdate _____ Age _____ Full-time Student Y or N

FAMILY MEMBERS

Name _____ Relationship _____

SSN ___-___-_____ Birthdate _____ Age _____

Full-time Student Y or N

Name _____ Relationship _____

SSN ___-___-_____ Birthdate _____ Age _____

Full-time Student Y or N

Name _____ Relationship _____

SSN ___-___-_____ Birthdate _____ Age _____

Full-time Student Y or N

Name _____ Relationship _____

SSN ___-___-_____ Birthdate _____ Age _____

Full-time Student Y or N

Name _____ Relationship _____

SSN ___-___-_____ Birthdate _____ Age _____

Full-time Student Y or N

Please note: Family members pertain only to you. If you are married, your spouse and dependent children are your family members. If you are not married, but have dependent children please list them. If you are single with no dependents, you would only list yourself. If the patient is a child, then parents and siblings would be listed. If you are a guardian, please list the child and provide proof.

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Please send documentation of the following income and assets for the entire household for 4 weeks prior to the date of service. (Except for self-employed see page 2) If the applicant is a minor, income for both parents must be provided.

INCOME SOURCE	DATE	AMOUNT
Wages before deductions (Stubs or Employer letter)	_____/____/_____	_____
Public Assistance	_____/____/_____	_____
Social Security Benefits	_____/____/_____	_____
Unemployment & Worker's Comp	_____/____/_____	_____
Strike Benefits from Union funds	_____/____/_____	_____
Veteran's Benefits	_____/____/_____	_____
Training Stipends	_____/____/_____	_____
Alimony	_____/____/_____	_____
Child Support	_____/____/_____	_____
Military Allotment Funds	_____/____/_____	_____
Regular Suport from an absent family member	_____/____/_____	_____
Pension Payments	_____/____/_____	_____
Insurance and Annuity payments	_____/____/_____	_____
Income from Estates and Trusts	_____/____/_____	_____
Dividends	_____/____/_____	_____
Interest Income	_____/____/_____	_____
Rental Income	_____/____/_____	_____
Royalties	_____/____/_____	_____
Other	_____/____/_____	_____

LIQUID ASSETS		
Cash	_____/____/_____	_____
Savings Accounts	_____/____/_____	_____
Checking Accounts	_____/____/_____	_____
Certificate of Deposit	_____/____/_____	_____
Treasury Bills	_____/____/_____	_____
Negotiable Paper	_____/____/_____	_____
Corporate Stocks and Bonds	_____/____/_____	_____
Real Estate Equity (other than primary residence)	_____/____/_____	_____
IRA's	_____/____/_____	_____
Other Liquid Assets	_____/____/_____	_____

NOTE: All liquid assets are considered at value on the date of service. All bank statements must show balance on date of service. Bank print-outs must show activity 30 days prior to the date of service along with balance on the date of service. All liquid assets must be fully documented.

PATIENT STATEMENT
Or parent of minor

PATIENT OR APPLICANT MUST SIGN ANY OF THE FOLLOWING STATEMENTS WHICH ARE APPLICABLE:

1. I attest that I have no income and have had no income since ____/____/_____.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

2. I attest that I have no bank accounts or any other means of liquid assets, through myself or any other party.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

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

_____ _____ ____/____/_____
(Signature) (relationship) (date)

4. I understand that unless I obtain a written Medicaid/Jersey Care denial for my child/children, they will not be covered under this program.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

5. I attest that these services are not related to motor vehicle or worker's compensation.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

6. I attest that I have no medical coverage through myself or any other party to cover the outstanding amount of this bill. I have no intentions of suing anyone, now, or in the future for compensation for these services.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

7. I understand that the information which I submit is subject to verification by the appropriate health care facility and Federal or State governments. Willful misrepresentation of the facts will make me liable for all hospital charges. I attest all information given is true and complete to the best of my knowledge.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

INTERVIEWER SIGNATURE _____ ____/____/_____

SPOUSE STATEMENT
Or parent of minor

PATIENT OR APPLICANT MUST SIGN ANY OF THE FOLLOWING STATEMENTS WHICH ARE APPLICABLE:

8. I attest that I have no income and have had no income since ____/____/_____.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

9. I attest that I have no bank accounts or any other means of liquid assets, through myself or any other party.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

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

_____ _____ ____/____/_____
(Signature) (relationship) (date)

11. I understand that unless I obtain a written Medicaid/Jersey Care denial for my child/children, they will not be covered under this program.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

12. I attest that these services are not related to motor vehicle or worker's compensation.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

13. I attest that I have no medical coverage through myself or any other party to cover the outstanding amount of this bill. I have no intentions of suing anyone, now, or in the future for compensation for these services.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

14. I understand that the information which I submit is subject to verification by the appropriate health care facility and Federal or State governments. Willful misrepresentation of the facts will make me liable for all hospital charges. I attest all information given is true and complete to the best of my knowledge.

_____ _____ ____/____/_____
(Signature) (relationship) (date)

INTERVIEWER SIGNATURE _____ ____/____/_____

SURVIVAL LETTER

TO WHOM IT MAY CONCERN:

I, _____ attest that I provide(d) the necessary room,
(name)

board, and other life essentials for _____ at my
(name of patient)

residence _____
(address)

since _____.
(date)

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

I understand, that I am not responsible for any hospital or other medically related

expense for _____.
(name of patient)

_____
(your signature)

Date: _____/_____/_____

Telephone: _____-_____-_____

To Whom It May Concern:

I, _____, attest that I have been a New

Jersey resident since _____.

I reside at _____

and intend to remain here.

I have not come to New Jersey for the sole purpose of receiving medical treatment. I have been residing in New Jersey before and at the time of service. I have not other residency in any other state or country.

Thank you,

X _____

Date: _____

Phone: _____

Note: Please complete this form only if you are supplying a piece of mail or utility bill as proof of residency. The documentation that you submit must have your name and address on it, plus a date or postmark. This information must be as of the date of service.

CAPE REGIONAL
MEDICAL CENTER

AUTHORIZATION FOR INFORMATION

ACCOUNT# _____

Name: _____
Address: _____
_____
_____

Soc Sec no: _____

I do hereby authorize and request disclosure to Cape Regional Medical Center any information from the Social Security Administration or any other source that may be desired concerning my age, residence, citizenship, employment, income, resources (assets), bank accounts and any Social Security benefits. It is understood that the information obtained will only be used for the purposes directly related to my eligibility for the New Jersey Hospital Care Assistance Program or New Jersey Medicaid.

_____ _____
Date Signature

_____ _____
Date Spouse

_____ _____
Date witnessed or rec'd Cape Regional Medical Center

Two Stone Harbor Boulevard, Cape May Court House, New Jersey 08210 (609) 463-2000