HACKETTSTOWN REGIONAL MEDICAL CENTER
Administrative Policy and Procedure

SECTION: FINANCE **Number: FI05**
Number of Pages: 1 of 1
Issue Date: June 1993
Revised/Reviewed Date: February 2008

TITLE: CHARITY PATIENTS

PURPOSE:

To provide medical services for indigent patients.

POLICY:

Hackettstown Regional Medical Center is required by law and the New Jersey licensing regulations to provide various medical and hospital services to patients who qualify for care at reduced rates or without charge. Cosmetic surgery does not come under these guidelines.

Qualification Requirements:

1. The financial eligibility of the patient or family wage earner must be determined by using the New Jersey State guidelines for charity care provided by the New Jersey Department of Health. This guideline takes into account the income of family members, size of family and their assets. After completion of the financial screening, done by the Financial Counselor, a clinic card is issued to the applicant. This card includes the applicant's name, address, eligible services and rate. The signature of the Financial Counselor completing the screening will appear on the card. The charity rate applies only to hospital service charges.

2. Financial screening is also available for individuals who were past hospital patients and are unable to pay their previously incurred hospital bills.

3. This is the policy in regard to medically indigent patients who apply either on an in-patient or outpatient basis, for financial assistance and consideration in obtaining health care services.

4. Eligibility is determined at time of screening. See attached form.

5. Charity care write offs are reviewed and approved by the Manager of Patient Business or Director of Budget and Reimbursement.

6. Obstetrical Patients: Refer to guidelines for Health Start Clinic.

Hackettstown Regional Medical Center
651 Willow Grove Street
Hackettstown, NJ 07840
(908) 852-5100 • www.hrmcnj.org

New Jersey Hospital Care Assistance Program
DETERMINATION OF APPLICATION FOR PARTICIPATION

SECTION I – Applicant Information

1. PATIENT NAME		2. FAMILY SIZE
3. DATE OF SERVICE	4. DATE OF DETERMINATION	5. DATE OF EXPIRATION
6. INCOME COMPUTATION		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.

PHYSICIAN BILLS ARE NOT COVERED UNDER CHARITY

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

Hospital Name and Address: Hackettstown Regional Medical Center
651 Willow Grove Street
Hackettstown, NJ 07840

Hospital Telephone Number: 908-852-5100

** 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 Assistance Program.

NAME OF EVALUATOR: Adrienne Werner TITLE: Coordinator

_____ _____
SIGNATURE DATE

Hackettstown Regional Medical Center

New Jersey 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) _____ (MI) _____

2. SOCIAL SECURITY NUMBER

___-___-____

3. DATE OF APPLICATION SERVICE

___/___/___
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 GUARTANTOR (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.

651 WILLOW GROVE STREET ▪ HACKETTSTOWN ▪ NEW JERSEY 07840-1798

PHONE (908) 852-5100

Hackettstown Regional Medical Center

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

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 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.

_____ _____

SIGNATURE OF PATIENT OR GUARANTOR DATE

Hackettstown Regional Medical Center

IF NO INCOME/ASSETS ARE CLAIMED, THE FOLLOWING STATEMENTS MUST BE SIGNED:

1. I attest that I have no income and have had no income from: _____ to _____.

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

2. I attest that I have no assets as listed on my Charity Application through myself or any other party.

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

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

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

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

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

5. I attest that I have not filed any income tax returns for the year of: _____.

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

6. I attest that my name is as written on the Charity Application.

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

7. I attest that I am a resident of the State of New Jersey.

   _____ _____ _____
   (Patient/Responsible Party) (Relationship) (Date)

8. I _____ attest that I recognize this applicant to be _____.

_____ _____
WITNESS DATE

Hackettstown Regional Medical Center

651 Willow Grove Street
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IF NO INCOME/ASSETS ARE CLAIMED, THE FOLLOWING STATEMENTS MUST BE SIGNED (2) :

9. I attest that I am legally married to my child/children's father/mother.

(Patient/Responsible Party) (Relationship) (Date)

10. I attest that I am legally divorced from my child/children's father/mother.

(Patient/Responsible Party) (Relationship) (Date)

11. I attest that I was never married to my child/children's father/mother.

(Patient/Responsible Party) (Relationship) (Date)

12. I attest that I DO NOT receive child support.

(Patient/Responsible Party) (Relationship) (Date)

13. I attest that I am NOT a New Jersey resident. I was admitted to the hospital as the direct result of an emergency.

(Patient/Responsible Party) (Relationship) (Date)

14. I attest that the information given is true and correct to the best of my knowledge.

(Patient/Responsible Party) (Relationship) (Date)

15. I fully understand and acknowledge that the New Jersey Assistance Program does not help with Doctors' bills and is only good for Hospital based services.

(Patient/Responsible Party) (Relationship) (Date)

WITNESS DATE

REASON FOR CHARITY CARE ELIGIBILITY

1. Not Enrolled In Medicare Program
2. Non Citizen Status
3. Exceeded Maximum Benefit Amount Per Spell Of Illness
4. Non Payment Of Premium For Medicare Part B Coverage
5. Non Covered Service
6. Medicare Part B Coverage Only
7. Medicare Deductibles/Co-Insurance

CHECKLIST FOR VARIOUS PROGRAMS

- ☐ Patient Does Not Fit Into Any Medicaid Categories (Blind, Disabled, Over The Age Of 65 Years, Or Pregnant).
- ☐ Over Income Limit For Medicaid.
- ☐ Alien Status – Not Eligible.
- ☐ Over Income Limit For Family Care PE Screening.
- ☐ Family Care Packet Given And Filled Out By Hospital.

New Jersey State Department of Health
Health Care for the Uninsured Program

NEW JERSEY HOSPITAL CARE PAYMENT ASSISTANCE FACT SHEET

WHAT IS THE HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM?

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care, which is provided to patients who receive inpatient, and outpatient service at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. Some service such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.

WHERE DOES FUNDING FOR HOSPITAL CARE PAYMENT ASSISTANCE COME FROM?

The source of funding for hospital care payment assistance is through the Health Care Subsidy Fund administered under Public Law 1996, Chapter 28.

WHO IS ELIGIBLE FOR HOSPITAL CARE PAYMENT ASSISTANCE?

Hospital care payment assistance is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: and
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid): and
3. Meet both the income and assets eligibility criteria listed below.

FAMILY SIZE	SCALE INCOME
1	20,420.00-30,631.00
2	27,380.00-41,071.00
3	34,340.00-51,511.00
4	41,300.00-61,951.00
5	48,260.00-72,391.00
6	55,220.00-82,831.00
7	62,180.00-93,271.00
8	69,140.00-103,711.00

Individual assets cannot exceed $7,500 and family assets cannot exceed $15,000.

You may request an appointment from the following department:

Adrienne Werner
Financial Coordinator (908) 850-6902

We will make a determination within five (5) working days of your request. An application found ineligible may reapply at a future time when applicant's circumstances have changed, making applicant eligible for charity care. Charity care and reduced charity care is available only for medically necessary care and sufficient documentation must be presented.

HACKETTSTOWN REGIONAL MEDICAL CENTER
651 WILLOW GROVE STREET
HACKETTSTOWN, NEW JERSEY 07840
(908) 852-5100

County Boards of Social Services

Atlantic County Department of Family & Community Development 1333 Atlantic Avenue Atlantic City, NJ 08401 (609) 348-3001	Mercer County Board of Social Services 200 Woolverton Street P.O. Box 1450 Trenton, NJ 08650-2099 (609) 989-4320
Bergen County Board of Social Services 216 Route 17 North 17 Park Office Center, Bldg. A Rochelle Park, NJ 07662-3300 (201) 368-4200	Middlesex County Board of Social Services 181 How Lane P.O. Box 509 New Brunswick, NJ 08903 (732) 745-3500
Burlington County Board of Social Services Human Services Facility 795 Woodlane Road Mount Holly, NJ 08060-3335 (609) 261-1000	Monmouth County Board of Social Services Kozloski Road P.O. Box 3000 Freehold, NJ 07728 (732) 431-6000
Camden County Board of Social Services Aletha R. Wright Administration Building 600 Market Street Camden, NJ 08102-1255 (856) 225-8800	Morris County Division of Employment and Temporary Assistance Program Services 340 West Hanover Avenue, P.O. Box 900 Morristown, NJ 07963-0900 (973) 326-7800
Cape May County Board of Social Services Social Services Building 4005 Route 9 South Rio Grande, NJ 08242-1911 (609) 886-6200	Ocean County Board of Social Services 1027 Hooper Avenue P.O. Box 547 Toms River, NJ 08754-0547 (732) 349-1500
Cumberland County Board of Social Services 1601 North Second Street, Building B Millville, NJ 08332 (856) 327-0114	Passaic County Board of Social Services 80 Hamilton Street Paterson, NJ 07505-2060 (973) 881-0100
Essex County Department of Citizen Services Division of Welfare 18 Rector Street – 1st floor Newark, NJ 07102 (973) 733-3000 ***Only for residents of Belleville, Irvington, Newark and Nutley***	Salem County Board of Social Services 147 South Virginia Avenue Penns Grove, NJ 08069-1797 (856) 299-7200
Essex County Department of Citizen Services Division of Welfare 50 S. Clinton Street, 2nd fl. E. Orange, NJ 07018 (973) 395-8000 ***All Other Areas of Essex County***	Somerset County Board of Social Services 73 East High Street P.O. Box 936 Somerville, NJ 08876-0936 (908) 526-8800
Gloucester County Board of Social Services 400 Hollydell Drive Sewell, NJ 08080-9318 (856) 582-9200	Sussex County Division of Social Services 18 Church Street P.O. Box 218 Newton, NJ 07860-0218 (973) 383-3600
Hudson County Division of Welfare John F. Kennedy Office Building 100 Newkirk Street Jersey City, NJ 07306 (201) 420-3000	Union County Board of Social Services 342 Westminster Avenue Elizabeth, NJ 07208-3290 (908) 965-2700
Hunterdon County Division of Social Services Community Services Center 6 Gauntt Place P.O. Box 2900 Flemington, NJ 08822-2900 (908) 788-1300	Warren County Division of Temporary Assistance and Social Services 501 Second Street Belvidere, NJ 07823 (908) 475-6301

Hackettstown Regional Medical Center

_____ DATE

_____ ADDRESS

_____

I _____ hereby state that I live at above address since _____. I have no source of income and no liquid assets or bank accounts.

_____
NAME

_____
WITNESS

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TO WHOM IT MAY CONCERN:

The Undersigned _____

(Relations to Patient) _____ provides the necessary room, board and other life essentials for _____ at my residence

_____

_____

_____

and have been doing this from _____ to _____

I am not responsible nor able to pay for any hospital or other medical expenses for him/her.

Signature _____ Date _____

Phone Number _____

New Jersey State Department of Health
Health Care for the Uninsured Program

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