254 Easton Avenue
New Brunswick, NJ 08901
732-745-8600 extension 5019
resourceservices@saintpetersuh.com

PATIENT NAME:
APPOINTMENT DATE/TIME:
RESOURCE ADVISOR:
DATE OF SERVICE:
ACCOUNT NUMBER:

FINANCIAL ASSISTANCE CHECKLIST

IDENTIFICATION:

Example: Birth certificate, social security card, driver's license, green card, passport, marriage certificate, county ID (with photo) for patient, spouse and children (if applicable).

IF YOU CURRENTLY HAVE INSURANCE: (Copy of Insurance Card)

Example: Medicare or Medicaid card, student health insurance card, primary/secondary health insurance. (If your child is eligible for Medicaid but does not have a card, please go to the Board of Social Services in your county to apply)

INCOME:

PATIENT: ONE (1) MONTH BEFORE _________________
Example: Pay stubs, letter from employer, unemployment stubs, Social Security printout, pension check stubs
NOTE: If you submit a letter from your employer, the letter must include the following: gross, weekly/bi-weekly/monthly salary, your date of hire and the hours worked during each pay period. In addition, the letter must have the company name and contact information OR **if unemployed, sign the enclosed letter.**

SPOUSE/PARENT: ONE (1) MONTH BEFORE _________________
Example: Pay stubs, letter from employer, unemployment stubs, Social Security printout, pension check stubs
NOTE: If you submit a letter from your employer, the letter must include the following: gross, weekly/bi-weekly/monthly salary, your date of hire and the hours worked during each pay period. In addition, the letter must have the company name and contact information OR **If unemployed, sign the enclosed letter.**

IF NO INCOME:
The patient must provide a separate signed statement in situations where there is no income, which includes an explanation of how he/she is living. Further, if there are others who provide the applicant with room and board or support, the hospital will request the applicant to provide written statements from those providing the support. **NOTE**: the statement should include the supporter's name, supporter's contact number, when the support started, address and proof of residency of the person providing support.

IF YOU ARE SELF EMPLOYED:
A Profit and Loss statement is needed for exactly three (3) months before the date of service. If you are self employed the state requires a Profit and Loss statement that must be drawn up by an accountant.
Example: if your date of service is 11/20/15, the Profit and Loss statement must be dated 08/20/15-11/20/15.

CHILD SUPPORT:

Please provide valid documentation showing monies received before ____________________

Example: Child support stubs from Probation Office, divorce decree (If it states how much and how often child support is received), or a letter stating no child support is received.

ASSETS:

Please provide valid documentation showing assets before__________________________(Patient / Spouse / Parent)

Example: Statement from bank or letter / printout from the bank stating account number, who is named on the account and balance on the above date. The letter / printout must either be on bank letterhead or have the bank's stamp on it. Mutual funds, life insurance, real estate equity other than primary residence, 401K. If no assets; a written statement stating no assets.

PROOF OF RESIDENCE:

Please provide valid documentation showing you are living at your address at least one (1) day before application date of

____

if you are applying for a prior date of service, please make sure the proof is dated one (1) day before that service.* (EXAMPLE**: utility bill, lease agreement, etc.)

INTENT TO STAY:

To be considered a New Jersey resident you must intend to stay living in New Jersey.

FINANCIAL AID AWARD LETTER: (Full time student)

If the patient (or any family member) is a full-time student, please provide proof of financial aid.

DIVORCE DECREE OR FIVE (5) POINTS OF SEPARATION:

1. Proof of separate property. Example: Lease, mortgage note, support letter which we will supply.
2. Proof of separate assets. Example: Statement / printout from bank or letter declaring no assets.
3. Tax return stating single filing or letter declaring no income or taxes were filed.
4. No contact/no financial ties letter. Must state no contact or financial ties for three (3) years or months
5. Copy of marriage certificate

We will also assist you in determining eligibility for the following programs:

- NJ FamilyCare – 1(800)701-0710
- Middlesex County Board of Social Services - (732) 745-3500
- Somerset County Board of Social Services (Medicaid Office) - (908) 526-8800
- Union County Board of Social Services (Medicaid Office) - (908) 791-7000
- Emergency Medicaid - PA1C required for emergency/labor and delivery

RESOURCE SERVICES REPRESENTATIVES ARE AVAILABLE:

HOSPITAL– Main Campus
254 Easton Avenue
(Ground Floor)
New Brunswick, NJ
MONDAY-FRIDAY 8:00 AM-4:00 PM

FAMILY HEALTH CENTER
123 How Lane
New Brunswick, NJ
MONDAYS, THURSDAYS AND FRIDAYS 8:00 AM-4:00 PM
TUESDAYS AND WEDNESDAYS 8:00 AM-7:00 PM

FOR MORE INFORMATION, PLEASE CALL (732) 745-8600 EXTENSION: 5019