



Dear Parent/ Guardian:

Thank you for choosing Children's Specialized Hospital to serve the needs of your child. Enclosed you will find an application for the Hospital Assistance Program. In order to be considered you must provide proof of being a permanent New Jersey resident and U.S. Citizen or a Legal Alien residing permanently in the United States. Approval and the amount of assistance you may receive are based upon a complete application, including your household income and assets. All information you provide must coincide with the dates of service for which you are applying.

We would like to extend this application to your family, even if your child has health insurance coverage. **Copayments are not included in the Hospital Assistance Program.** However, the applicant and/or the guarantor agree to follow all insurance guidelines including, but not limited to, obtaining referrals, authorizations, and precertifications. If the applicant and/or the guarantor do not follow all individual insurance plan requirement(s), the applicant and/or the guarantor will be responsible for all charges incurred, that are not covered or denied by their insurance.

The applicant and/or the guarantor must apply, in a timely manner, for any governmental and/or private medical assistance or alternative funding sources that the patient, the applicant and/or the guarantor may be eligible for. Proof of denial and/or eligibility of such is required to issue the final determination of the submitted Hospital Assistance Program application. Approvals for the Hospital Assistance Program are contingent on the receipt of denial or acceptance into such assistance, this information must be supplied to Children's Specialized Hospital in a timely manner.

***By submitting your application, you understand that you are responsible for the accuracy of information provided, for following insurance guidelines, and for re-applying as needed. Hospital Assistance, if approved, will be valid for one year from the date of service or approval date. You are responsible for re-applying prior to the expiration of the approved, for the following year.***

Information submitted for consideration in the Hospital Assistance Program is subject to verification by Children's Specialized Hospital and/or Federal or State Governments. Willful misrepresentation of facts will make the applicant and/or the guarantor liable for all hospital charges, and subject to civil penalties. By submitting the application you certify that all information and documentation required for processing the Hospital Assistance Application is true and correct, and understand that it is the responsibility of the applicant and/or guarantor to advise Children's Specialized Hospital, immediately, of any change in status regarding residency, family size, income, or assets.

If you have any questions, or need assistance completing this application, please call (908)301-5480. You may return your **completed** application by one of the following methods:

- Mail: Children's Specialized Hospital **ATTN: Patient Access Services** 150 New Providence Road, Mountainside, NJ 07092
- Fax: 908-301-5593
- Drop-off at any of our locations.

Please allow two weeks for processing once received at Children's Specialized Hospital. Once a determination is made, we will notify you via mail. **In order to expedite your application, please be sure to include all necessary documents as listed on the next page.**

Sincerely,  
Director, Patient Access Services

**Children's Specialized Hospital  
Hospital Assistance Program  
Application for Participation**

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**Listed below are documents that must be submitted with your Hospital Assistance application. Please send copies, not originals.**

**Requested Date of Service \_\_\_\_\_**

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You must provide information for the *entire* month prior to the requested date of service. When applying for HAP coverage for servicers already rendered, you must provide information for the month prior to the first treatment session. i.e. If first treatment was on June 1<sup>st</sup> 2011, information must be provided for the month of May 2011.

**The following items are required and must be received within 30 days in order to process the application:**

1. Income Information. Please provide:
  - If employed:
    - Two pay stubs from the month prior to requested date of service from each working member of the household
  - If self-employed:
    - Statement from certified accountant showing income from the month prior to requested date of service
    - Bank statements confirming income
  - If no family members in the household are working:
    - Two most current disability and/or unemployment checks
  - Provide legal documents for the following sources of income:
    - Social security
    - Child Support Payments
    - Alimony Payments
  - Provide checks for the following sources of income from the month prior to requested date of service:
    - Rental Income
    - Interest Income (must show source of interest)
  - All other sources of Income
2. Most recently filed Income Tax Return
3. Most current W2 Forms from each working member of the household
4. Statements from all checking and savings accounts of all members of the household from the month prior to requested date of service.
5. Proper documentation proving permanent New Jersey residency, United States Citizenship or legal Alien Residency for the patient.
  - *Examples of valid documents: Birth Certificate, Social Security Card or United States Passport, Green Card*
6. Driver's license or proper photo ID
7. Health Insurance ID Cards (If you have health insurance)
8. Proof of denial and/or eligibility of any governmental and/or private medical assistance or alternative funding source(s) that patient, family and/or guarantor is eligible if family is uninsured
9. Asset Documentation

- This includes stocks, bonds and any other investments including property other than your primary residence. Property other than that in/on which is the guarantor/families primary residence is considered an asset and will be considered when making an eligibility determination. Assets such as (but not limited to) checking and savings, stocks and bonds other than those in designated retirement accounts, are considered in making a determination, where investment retirement plans such as (but not limited to) 401(K) or 403 (B) plans are not considered.
- *Examples of valid documents: Most recent monthly statement of stocks, funds and bonds*

**IMPORTANT:**

- **If any of the above required documents are not received, the application will be denied.**
- **Eligibility for HAP is based solely on your total household income and asset value. Expenditures will not be considered when determining your eligibility.**

**Children's Specialized Hospital  
Hospital Assistance Program  
Application for Participation**

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\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
NJ  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Petitioner's Name

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Patient Social Security Number

\_\_\_\_\_  
Household Size\*

(WHAT EVER IS CLAIMED TO THE GOVERNMENT/IN THEIR TAX RETURN)

\_\_\_\_\_  
Requested Date of Service (MUST PROVIDE PAY STUBS)

\_\_\_\_\_  
Type of Service & Location

*NJ Permanent Resident?* \_\_\_\_\_

*U.S. Citizen?* \_\_\_\_\_ *If no...What is the residency status of the family?* \_\_\_\_\_

\*A pregnant woman is counted as 2 household members.

On the back of this form, list all household members and their relationship to the patient.

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**Petitioner's Certification**

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I understand that the information submitted for consideration in the Hospital Assistance Program is subject to verification by Children's Specialized Hospital and/or Federal or State Governments. Willful misrepresentation of facts will make me and/or the guarantor liable for all hospital charges, and subject to civil penalties. I certify that all information provided and documentation required for processing the Hospital Assistance Application is true and correct, and understand that it is my responsibility to advise Children's Specialized Hospital immediately of any change in status regarding my residency, family size, income, or assets.

I and/or the guarantor agree to follow all insurance guidelines including, but not limited to, referrals, authorizations, and precertifications. If I and/or the guarantor do not, I and/or the guarantor will be responsible for all charges incurred that are not covered by insurance.

I and/or the guarantor will apply, in a timely manner, for any governmental or private medical assistance or alternative funding sources that the patient, myself and/or the guarantor may be eligible for and provide proof of denial or eligibility of such. I am aware that failure to provide proof of denial or acceptance will result in denial of my Hospital Assistance Program application. I am aware that my application for the Hospital Assistance Program is contingent on providing proof of denial or acceptance into such assistance in a timely manner.

\_\_\_\_\_  
Signature of Petitioner

\_\_\_\_\_  
Date

