CHEMED
CENTER FOR HEALTH EDUCATION MEDICINE & DENTISTRY

1771 Madison Avenue
Lakewood, NJ 08701
P: 732-364-2144
F: 732-364-3559
E: info@chemedhealth.org

ELIGIBILITY CRITERIA

PLEASE PROVIDE THE FOLLOWING DOCUMENTS FOR COMPLETION OF YOUR APPLICATION:

1. IDENTIFICATION
   The following forms of ID are acceptable:
   - Valid Photo Driver's License
   - Birth Certificate for all family members
   - Social Security Cards for all family members
   - Alien Registration Card, Green Card (date of entry must be legible)
   - Valid Passport
   - Employee Photo ID
   - Public Assistance Identification Card

****please provide one form of ID for everyone listed on the application**

****if you are legally married please provide your marriage certificate if I.D. and documents are in different names**

2. PROOF OF INCOME
   The following forms of proof of income are acceptable:
   - Current pay stubs (last 4 weeks of pay)
   - Unemployment pay stubs (last 2 stubs or award letter)
   - Social Security Entitlement- Social Security Disability
   - Statement from employer stating date of hire, hours worked and gross income
   - Self employed: Most recent period income tax return; may need additional income proof
   - No Income: Please provide a "letter of support." The letter must state the name and address of the person responsible for providing your basic needs, including rent or shelter and food. We also require an ID for the person who writes the support letter.
3. ELIGIBILITY FOR PUBLIC ASSISTANCE
   - Proof of denial from Medicaid
   - For children up to and including age 18, parents must apply for Jersey Care. Proof of application and the status of the application (pending or denial) must be provided.
   - If you are not working you must go to the board of social serviced (General Assistance) to see if you qualify for any of their programs. If they tell you that you don't qualify for general assistance you must get their denial letter to submit to us.
4. PROOF OF RESIDENCE
   - Utility Bill (gas, electric, water or phone bill addressed to you one month prior to date of service)
   - Current received mail (post date) etc.
   - Letter from person you live with stating the length of time at present address and their utility bill.
5. MEDICAL INSURANCE
   - Insurance card (for dental, and high deductable plans)

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Medical Assistance Application – Page 1

Applicant (Patient) Name: _____ **Date:** / /
(Last) *(First)*

Address: _____ **Phone #:** _____
Street, Suite *City* *State* *Zip*

CITIZENSHIP: US Citizen **G**reen Card (need date of entry) **Non** US Citizen

Marital Status: Single **M**arried **Sep**arated **D**ivorced **W**idowed

Family Size – Please list all dependents l

RACE: **W**hite **A**frican American **H**ispanic **O**ther

	Last Name, First Name	GENDER	DOB (MM/DD/YYYY)	RACE	CITIZEN	MARITAL	Relationship to patient
1.							**Patient**
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Household Income

Household member receiving income (including children)	Employer Name • self-employed write "Self-employed" • Owner write "owner"	Full-time or Part-time		How often paid (check one box)					Gross income per pay period
		FT	PT	Weekly	Bi-weekly	Monthly	Semi-Monthly	Annually	
		❑	❑	❑	❑	❑	❑	❑	$
		❑	❑	❑	❑	❑	❑	❑	$
		❑	❑	❑	❑	❑	❑	❑	$

Do you or any household member receive any other source of income: $ ❑weekly ❑biweekly ❑monthly ❑semi-monthly ❑annually

Total Annual Household Income $

Proof of family income: (check all that apply)
❑ Paycheck ❑ Unemployment benefit ❑ Employer statement ❑ Disability benefit
❑ Income tax return ❑ Child support payment ❑ Support attestation ❑ Other _____

Do you have any of the following: ❑No
❑Private Insurance ❑Medicaid ❑NJ Family Care ❑Medicare ❑Travelers Insurance:
If yes, does it cover dental ❑Yes ❑No **Effective date:** / /

I certify that the family size and income information shown above is correct. Copies of ID for every family member, tax returns, pay stubs and other information verifying income, and proof of residency are required before a discount is approved.
I understand that based on the above information, I may not be eligible for financial assistance. I understand that I may be required to follow up to qualify for financial assistance. If I am not eligible for financial assistance, I understand that I will be held responsible for the balance on my account(s).

PLEASE NOTE VACCINES AND LAB WORK ARE NOT COVERED UNDER THE SLIDING FEE. DENTAL LAB FEES FOR CROWNS ON IMPLANTS MAY BE AS HIGH AS $500. THE LAB FEE IS NOT INCLUDED IN YOUR DISCOUNT.

Print Name *Signature* *Date*

-- OFFICE USE ONLY --

Family income bracket: ❑ 100% ❑ 133% ❑ 166 % ❑ 200% ❑201% ❑250% ❑350%

If patient is uninsured, were they referred or did they apply for medical assistance? ❑Referred ❑Applied ❑None If yes, date of referral: / /

Patient approved for: ❑Plan A ❑Plan B ❑Plan C ❑Plan D ❑ Plan E

Approved and verified by (Print) _____ Signature _____ Date _____ Valid until _____

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MEDICAL ASSISTANCE REFERRAL FORM – Page 2

Date: / /

Patient Last Name _____ Patient First Name _____

Section I: All information will be kept strictly confidential

Annual Family Income $ _____

Monthly Family Income (Divided annual by 12) $ _____

Behavioral Health	**$ 40.00**	**$ 50.00**	**$ 60.00**	**$ 80.00**	**$ 100.00**
Medical	**$ 20.00**	**$ 25.00**	**$ 30.00**	**$ 40.00**	**100%**
Dental & Nutrition	**25%**	**40%**	**50%**	**75%**	**100%**
Scale Level	**A**	**B**	**C**	**D***	**E**
Poverty level 2014	**100%**	**133%**	**200%**	**250%**	**more**
Family Size	**Maximum Annual Income**				
1	11,670	15,521	23,340	29,175	29,176
2	15,730	20,921	31,460	39,325	39,326
3	19,790	26,321	39,580	49,475	49,476
4	23,850	31,721	47,700	59,625	59,626
5	27,910	37,120	55,820	69,775	69,776
6	31,970	42,520	63,940	79,925	79,926
7	36,030	47,920	72,060	90,075	90,076
8	40,090	53,320	80,180	100,225	100,226
9	44,150	58,720	88,300	110,375	110,376
10	48,210	64,119	96,420	120,525	120,526
11	52,270	69,519	104,540	130,675	130,676
12	56,330	74,919	112,660	140,825	140,826
13	60,390	80,319	120,780	150,975	150,976
14	64,450	85,719	128,900	161,125	161,126
each individual	**$ 4,060.00**	**$ 5,399.80**	**$ 8,120.00**	**$ 10,150.00**	

Dental Patients ❒ I have Medical Insurance – if yes, please skip next 2 sections and go to signature line below

The patient will not be referred for Medicaid/ NJ Family Care/ other governmental medical assistance program because (check all that apply)

❒ Monthly family income is too high ☐earned ☐unearned

❒ Unqualified alien ☐ Non citizen ☐ Green card < 5 years

❒ No minor children ☐ Age 19-64 with no dependents

❒ Female: Not pregnant ☐ Not disabled

❒ Patient unable to document alien status

❒ Not NJ resident

❒ Not over 65 yrs

❒ Other

Section III: *(this section is to be completed by the patient)*

❒ I understand that I/my dependant may qualify for the above referenced programs. I accept the referral, and agree to apply for medical assistance.

❒ I understand that I/ my dependant does not qualify for any above referenced programs, consequently I/ my dependant is not being referred for medical assistance.

☐ I already applied to Medicaid and am waiting for a reply.

❒ I understand that I/ my dependant may qualify for one of the above referenced programs. However, I am not interested in applying for any of the medical assistance programs.

Signature of Patient/Guardian: _____ Date: _____

Signature of Chemed Staff : _____ Date: _____

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PLEASE COMPLETE THIS FORM IF YOU RECEIVE FINANCIAL OR HOUSING ASSISTANCE

This form must be signed by benefactor (please provide ID)

Patient Name: _____ Patient Date of Birth: _____

To Whom It May Concern:

I, (print supporter's name) _____ (Relation to patient _____),

- ☐ Provide a monthly support of $_____
- ☐ Provide this patient with room and board and do not give any cash support at this time. He/ she is unemployed and does not have any source of income.

My address is: _____

_____

Telephone #: _____

Please note I am not responsible to pay for any medical expenses for this patient.

Signature: _____ Date: _____

Staff signature_____ Date: _____