



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 deductible plans)



**Medical Assistance Application – Page 1**

**Applicant (Patient) Name:** \_\_\_\_\_ **Application Date:** \_\_\_\_\_

(Last) (First)

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Street, Suite City State Zip

**CITIZENSHIP:** US Citizen **Green Card** (need date of entry) **Non US Citizen** | **Marital Status:** Single **Married** **Sep**arated **D**ivorced **W**idowed

**Family Size** – Please list all dependents including yourself | **RACE:** White African American Hispanic Other

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

**Household Income**

Household member receiving income (including children)	Employer Name <small>• self-employed write "Self-employed" • Owner write "owner"</small>	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	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$

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

**Total Annual Household Income** \$ \_\_\_\_\_

**Is anyone in your household pregnant**  Yes - Due Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  No

**Do you have any of the following:**  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 \$600. THE LAB FEE IS NOT INCLUDED IN YOUR DISCOUNT.**

<i>Print Patient or Guardian Name</i>	<i>Signature of Patient or Guardian</i>	<i>Date</i>
-- OFFICE USE ONLY --		
Patient approved for: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G		
Approved and verified by (Print)	Staff Signature	Date
		Valid until





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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: \_\_\_\_\_