



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
- Copy of tax return with dependents listed on it

****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
- Most recent period income tax return
- 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)
- Valid NJ driver's license
- 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)



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Letter of Support

Patient Name: _____ Patient Date of Birth: _____

To Whom It May Concern:

I, (print supporters 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 located at: _____

Telephone #: _____

***I.D. of the supporter is required**

Please note I am not responsible, nor able to pay for any medical expenses for this patient.

Signature: _____

Date: _____

Staff signature _____

Date: _____