CHEMED
CENTER FOR HEALTH EDUCATION MEDICINE & DENTISTRY

Financial Assistance Application – Page 1

Applicant (Patient) Name: *(Last) (First)* **Application Date:**

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

CITIZENSHIP (required only for NJ LOA): **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 including yourself

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

	Last Name, First Name	GENDER	DOB (MM/DD/YYYY)	RACE	CITIZEN (NJ LOA)	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 $

Is anyone in your household pregnant ❑Yes – Due Date: _____ / ____ / _____ ❑No

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 that direct costs, such as IUD's and pharmaceuticals may not be covered under the sliding fee.

Print Patient or Guardian Name ***Signature of Patient or Guardian*** *Date*

-- OFFICE USE ONLY --

Patient approved for: ❑Plan A ❑Plan B ❑Plan C ❑Plan D ❑ Plan E ❑ Plan F (NJ LOA)

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

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Financial Assistance Application – 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) $ _____

Scale Level	A	B	C	D	E	F	G
Behavioral Health	$ 30.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	$ 100.00	**$ 115.00**
Medical	$ 25.00	$ 30.00	$ 35.00	$ 40.00	$ 40.00	$ 40.00	**100%**
Podiatry	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	**100%**
Womens Health	$ 25.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	**100%**
Specialty Services*	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	**100%**
Nutrition	$ 45.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	100%	**100%**
Radiology	$ 45.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	100%	**100%**
Mammography	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	$ 40.00	**100%**
Dental	$ 49.00	40%	50%	55%	60%	75%	**100%**
Pharmacy Dispensing Fee*	$ 2.00	$ 4.00	$ 6.00	$ 8.00	$ 10.00	100%	**100%**

Scale Level	A	B	C	D	E	F**	G
Poverty level 2022	**100%**	**125%**	**150%**	**175%**	**200%**	**250%**	**more**
Family Size	**Maximum Annual Income**						
1	13,590	16,988	20,385	23,783	27,180	33,975	33,976
2	18,310	22,888	27,465	32,043	36,620	45,775	45,776
3	23,030	28,788	34,545	40,303	46,060	57,575	57,576
4	27,750	34,688	41,625	48,563	55,500	69,375	69,376
5	32,470	40,588	48,705	56,823	64,940	81,175	81,176
6	37,190	46,488	55,785	65,083	74,380	92,975	92,976
7	41,910	52,388	62,865	73,343	83,820	104,775	104,776
8	46,630	58,288	69,945	81,603	93,260	116,575	116,576
9	51,350	64,188	77,025	89,863	102,700	128,375	128,376
10	56,070	70,088	84,105	98,123	112,140	140,175	140,176
11	60,790	75,988	91,185	106,383	121,580	151,975	151,976
12	65,510	81,888	98,265	114,643	131,020	163,775	163,776
13	70,230	87,788	105,345	122,903	140,460	175,575	175,576
14	74,950	93,688	112,425	131,163	149,900	187,375	187,376
each individual	**$ 4,720.00**	**$ 5,900.00**	**$ 7,080.00**	**$ 8,260.00**	**$ 9,440.00**	**$ 11,800.00**	

* Not included above are direct costs for pharmaceuticals, IUD's which will be the responsibility of the patient.

** The NJ Aid discount program for income levels 200%-250% and is only available for NJ Residents.

Signature of Patient/Guardian: _____ Date _____

Signature of CHEMED Staff: _____ Date _____