CHEMED
CENTER FOR HEALTH EDUCATION MEDICINE & DENTISTRY

## 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.
   - Fill out self-attestation form.

3. PROOF OF RESIDENCE
   - Utility Bill (gas, electric, water or phone bill addressed to you one month prior to date of service)
   - Current received mail (postdate) etc.
   - Letter from person you live with stating the length of time at present address and their utility bill.

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## 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: S**ingle **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 | 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

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** |
|---|---|---|---|---|---|---|
| **Behavioral Health** | $ 45.00 | $ 50.00 | $ 55.00 | $ 60.00 | $ 65.00 | $ 100.00 |
| **Medical** | $ 25.00 | $ 30.00 | $ 35.00 | $ 40.00 | $ 40.00 | $ 40.00 |
| **Podiatry** | $ 20.00 | $ 25.00 | $ 30.00 | $ 35.00 | $ 40.00 | $ 40.00 |
| **Specialty Services*** | $ 20.00 | $ 25.00 | $ 30.00 | $ 35.00 | $ 40.00 | $ 40.00 |
| **Nutrition** | $ 45.00 | $ 50.00 | $ 55.00 | $ 60.00 | $ 65.00 | 100% |
| **Radiology** | $ 45.00 | $ 50.00 | $ 55.00 | $ 60.00 | $ 65.00 | 100% |
| **Mammography** | $ 20.00 | $ 25.00 | $ 30.00 | $ 35.00 | $ 40.00 | $ 40.00 |
| **Dental** | $ 49.00 | 40% | 50% | 55% | 60% | 100% |
| **Pharmacy Dispensing Fee*** | $ 2.00 | $ 4.00 | $ 6.00 | $ 8.00 | $ 10.00 | 100% |
| **Scale Level** | **A** | **B** | **C** | **D** | **E** | **F**** |
| **Poverty level 2019** | **100%** | **125%** | **150%** | **175%** | **200%** | **250%** |
| **Family Size** | **Maximum Annual Income** | | | | | |
| **1** | 12,490 | 15,613 | 18,735 | 21,858 | 24,980 | 31,225 |
| **2** | 16,910 | 21,138 | 25,365 | 29,593 | 33,820 | 42,275 |
| **3** | 21,330 | 26,663 | 31,995 | 37,328 | 42,660 | 53,325 |
| **4** | 25,750 | 32,188 | 38,625 | 45,063 | 51,500 | 64,375 |
| **5** | 30,170 | 37,713 | 45,255 | 52,798 | 60,340 | 75,425 |
| **6** | 34,590 | 43,238 | 51,885 | 60,533 | 69,180 | 86,475 |
| **7** | 39,010 | 48,763 | 58,515 | 68,268 | 78,020 | 97,525 |
| **8** | 43,430 | 54,288 | 65,145 | 76,003 | 86,860 | 108,575 |
| **9** | 47,850 | 59,813 | 71,775 | 83,738 | 95,700 | 119,625 |
| **10** | 52,270 | 65,338 | 78,405 | 91,473 | 104,540 | 130,675 |
| **11** | 56,690 | 70,863 | 85,035 | 99,208 | 113,380 | 141,725 |
| **12** | 61,110 | 76,388 | 91,665 | 106,943 | 122,220 | 152,775 |
| **13** | 65,530 | 81,913 | 98,295 | 114,678 | 131,060 | 163,825 |
| **14** | 69,950 | 87,438 | 104,925 | 122,413 | 139,900 | 174,875 |
| **each individual** | **$ 4,420.00** | **$ 5,525.00** | **$ 6,630.00** | **$ 7,735.00** | **$ 8,840.00** | **$ 11,050.00** |

* 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 _____