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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CENTER FOR HEALTH EDUCATION MEDICINE & DENTISTRY

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%**
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%	100%	**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 2021	**100%**	**125%**	**150%**	**175%**	**200%**	**250%**	**more**
	Maximum Annual Income						
1	12,880	16,100	19,320	22,540	25,760	32,200	32,201
2	17,420	21,775	26,130	30,485	34,840	43,550	43,551
3	21,960	27,450	32,940	38,430	43,920	54,900	54,901
4	26,500	33,125	39,750	46,375	53,000	66,250	66,251
5	31,040	38,800	46,560	54,320	62,080	77,600	77,601
6	35,580	44,475	53,370	62,265	71,160	88,950	88,951
7	40,120	50,150	60,180	70,210	80,240	100,300	100,301
8	44,660	55,825	66,990	78,155	89,320	111,650	111,651
9	49,200	61,500	73,800	86,100	98,400	123,000	123,001
10	53,740	67,175	80,610	94,045	107,480	134,350	134,351
11	58,280	72,850	87,420	101,990	116,560	145,700	145,701
12	62,820	78,525	94,230	109,935	125,640	157,050	157,051
13	67,360	84,200	101,040	117,880	134,720	168,400	168,401
14	71,900	89,875	107,850	125,825	143,800	179,750	179,751
each individual	**$ 4,540.00**	**$ 5,675.00**	**$ 6,810.00**	**$ 7,945.00**	**$ 9,080.00**	**$ 11,350.00**	

* 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 _____