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New Jersey State Department of Health Health Care for the Uninsured Program

NEW JERSEY HOSPITAL CARE PAYMENT ASSISTANCE FACT SHEET



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WHAT IS THE HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM?

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction. Hospital financial counselors can answer an applicant's questions about which services are covered by the New Jersey Hospital Care Payment Assistance Program.

WHERE DOES FUNDING FOR HOSPITAL CARE PAYMENT ASSISTANCE COME FROM?

The source of funding for hospital care payment assistance is through the Health Care Subsidy Fund administered under Public Law 1997, Chapter 263.

WHO IS ELIGIBLE FOR HOSPITAL CARE PAYMENT ASSISTANCE?

Hospital care payment assistance is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: and
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and
3. Meet both the income and assets eligibility criteria listed below.

Hospital assistance is also available to non-New Jersey residents, subject to specific provisions. Note that the Hospital Care Payment Assistance Program is not considered health insurance.

Income Criteria

<u>Income as a Percentage of HHS Poverty Income Guidelines</u>	<u>Percentage of Charge Paid by Patient</u>
less than or equal to 200%	0%
greater than 200% but less than or equal to 225%	20%
greater than 225% but less than or equal to 250%	40%
greater than 250% but less than or equal to 275%	60%
greater than 275% but less than or equal to 300%	80%
greater than 300%	100%

If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered hospital care payment assistance.

Assets Criteria

Individual assets cannot exceed \$7,500 and family assets cannot exceed \$15,000. Should an applicant's assets exceed these limits, he/she may "spend down" the assets to the eligible limits through payment of the excess toward the hospital bill and other approved out-of-pocket medical expenses.

HOW ARE INDIVIDUALS MADE AWARE OF THE AVAILABILITY OF HOSPITAL CARE PAYMENT ASSISTANCE?

Hospitals post signs in English, Spanish and any language which is spoken by 10% or more of the population in the hospital's service area. These signs are posted in appropriate areas of the facility such as the admissions area, the business office, outpatient clinic areas, and the emergency room. The sign informs patients of the availability of hospital assistance and reduced charge care, gives a brief description of the eligibility criteria, and directs the patient to the business office or admissions office of the hospital. Every patient should receive a written notice of the availability of hospital care payment assistance and medical assistance.

WHAT ARE THE SCREENING PROCEDURES FOR THIRD PARTY PAYERS AND MEDICAID?

All charity care applicants must be screened by the hospital to determine potential eligibility for any third-party insurance benefits, Medicaid or other medical assistance programs that might pay towards the hospital bill.

Patients should only apply for the hospital care payment assistance program when they are determined to be ineligible for Medicaid or any other medical assistance programs. Patients are responsible to obtain a financial screening from other medical assistance programs in a timely manner.

Once the hospital has informed the patient about other medical assistance and/or makes the referral properly, if the patient fails to cooperate or does not go for screening in a timely manner, the hospital has the option to bill the patient and pursue collection efforts, regardless of eligibility for hospital care payment assistance.

HOW DOES SOMEONE APPLY FOR HOSPITAL CARE PAYMENT ASSISTANCE?

The patient or prospective patient must apply for hospital care payment assistance at the hospital from which he/she plans to obtain or has obtained services. The patient should apply at the business office or admissions office of the hospital. The patient or responsible party must answer questions related to his/her income and assets, as well as provide documentation of the income and assets. The hospital will make a determination of whether the applicant is eligible as soon as possible, but no more than ten working days from the time a complete application is submitted. If the request does not include adequate documentation to make a determination, the request shall be denied. The applicant will then be allowed to present additional documentation to the hospital. The applicant has up to one year from the date of service to apply for hospital assistance and provide the hospital with a completed application. Applicants found ineligible may reapply at a future time when they present themselves for services and believe their financial circumstances have changed.

The Department of Health has a toll-free number to assist with any questions or concerns. Please call the Health Care for the Uninsured Program during business hours at 1-866-588-5696 or 609-292-4709.