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 Certificates for all family members
- Social Security Cards for all family members
- Alien Registration Card (Green Card)
- Valid Passport
- Employee Photo ID
- Public Assistance Identification Card

Please provide at least one form of ID for everyone listed on the application
*** If you are legally married please provide your marriage certificate***

2. PROOF OF INCOME

The following forms of proof of income are acceptable:

- Current pay stubs (last 4 consecutive stubs)
- Unemployment pay stubs (last 3 stubs)
- 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 from 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 NJ FamilyCare first. 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 services (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 dated) etc.
- Letter from person you live with stating the length of time at present address and their utility bill.

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You must be a registered patient of MFHC (Monmouth Family Health Center) in order to receive services. Also, you may not be approved for the Reduced Fee Program until your application is complete.

SLIDING FEE SCALE PROGRAM QUESTIONS AND ANSWERS

What are the effective dates of coverage for the Sliding Fee Scale Program?
The effective date of coverage for this program is immediate upon approval of the completed applications. Approval is valid for one year. Application must be renewed annually.

When am I eligible to apply and when must the application be submitted?
You are eligible to apply and your application can be submitted at any time that you are registered as a patient of Monmouth Family Health Center.

How do I enroll?
Complete the application and submit all required documentation to the Financial Counselor at MFHC. You will be notified upon determination of your eligibility and approval.

Can I include my spouse and children in the Program?
If information is provided for each member of the family at the time of the application, your spouse and children will be included in the program upon approval of the application.

Can I choose my provider at MFHC?
All MFHC patients have the option to choose the MFHC physician of their choice. In the event the medical provider chosen has no openings for new patients, individuals can elect a second choice or be assigned to a provider with immediate openings, or they can elect to wait to be scheduled to see the provider of their first choice.

What if I need to see a Specialist or need diagnostic services such as X-Ray or Laboratory services?
MFHC does not cover specialty care or diagnostic services, nor is any program or service that is not directly operated by MFHC covered under this program. You may be eligible to apply directly to the provider of such services for their reduced fee or un-reimbursed care programs. MFHC will to the extent possible provide you with referrals for these services.

Must I pay for any part of the service and when is payment due?
All patients approved for the Sliding Fee Scale Program are expected to pay $30 for medical services. Dental service fees are based upon the type of procedure performed and you will be advised of the Dental fee at that time. Patients approved for the Sliding Fee Scale Program are expected to pay the determined fee at the time of each MFHC primary care visit.

How can I apply for the Sliding Fee Scale program?
Patients may contact the Financial Counselor at (732) 923-7103 or (732) 963-0164 to request that information be mailed to them or complete the application process at MFHC.

What information should I bring for the appointment?
See the attached list of required documents for the program.

Who can I call with questions?
Call the Financial Counselor at (732) 923-7103 or (732) 963-0164 for questions specific to the application process.
Thank you.

FQHC HEALTHCARE EXPANSION PROGRAM
UNINSURED CARE APPLICATION

PATIENT INFORMATION

Name: _____
Address: _____
_____
Telephone: ____(_____)_____
Linked Patient Chart # _____
Was the patient born in the US? ( ) yes ( ) no

Date of Application: _____/_____/_____
Birth Date: _____/_____/_____
Family size: _____
(include immediate family members in household, spouse, parents, guardians, Children under 21)

MARITAL STATUS

_____single
_____married
_____separated
_____divorced
_____widowed

PATIENT ID (maintain copy)

_____driver license
_____Social Security card
_____INS/welfare card
_____alien registry card
_____other_____

HEALTH INSURANCE STATUS (maintain copy)

Does patient have any of the following? _____Private Ins. _____Medicaid _____NJ FamilyCare
_____Welfare _____SSI _____Medicare

If yes, effective date: _____/_____/_____

SCREENING FOR MEDICAL ASSISTANCE

If patient is uninsured, was he/she referred for medical assistance? _____yes _____no
If yes, date of referral: _____/_____/_____

INCOME INFORMATION (maintain copy)

Is patient/guardian(s) currently employed? _____yes _____no
Total family income per month: $_____ per year: $_____
Proof of family income (check all that apply):

_____paycheck _____child support payment _____disability benefit
_____unemployment benefits _____foster care benefit _____other
_____income tax return _____employee statement

In case of emergency, contact: _____ (_____)_____

I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Patient (Parent/Guardian) Signature Date

==========**HEALTH CENTER USE ONLY**==========

Center employee verifying above information: _____
Signature

Twelve month reassessment of continuing eligibility, including current income and insurance status (updated income and insurance documentation must be maintained in patient file):

_____/_____/_____ _____ _____/_____/_____ _____
Date Initials Date Initials

MEDICAL ASSISTANCE REFERRAL FORM

Patient Name: _____ **Patient ID#** _____

SECTION 1

Annual Family Income $_____

Divided by 12 (Monthly Family Income) $_____

Birth Date of Patient: _____/_____/_____ Age of Patient: _____

Was Patient Born in the U.S.? _____Yes _____No Family Size: _____

If no, date of arrival in the U.S. _____/_____/_____

SECTION II (*circle the box that applies; if no box applies go to* ***SECTION III***)

***Plus any additional procedure charge(s).**

	A	B	C	D	E	F	G	H
	<100%	101% <120%	121%<140%	141%<180%	181%<200%	201% <250%	251%<300%	>301%
Fam Size	Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays
	$30	$35	$40	$45	$50	$60	$70	100% of charges
1	$13,590 or less	$13,591 - $16,309	$16,310 - $19,026	$19,027 - $24,462	$24,463 - $27,180	$27,181 - $33,972	$33,976 - $40,770	$40,771 or More
2	$18,310 or less	$18,311 - $21,972	$21,973 - $25,634	$25,635 - $32,958	$32,959 - $36,620	$36,621 - $45,775	$45,776 - $54,930	$57,931 or More
3	$23,030 or less	$23,031 - $27,636	$27,637 - $32,242	$32,243 - $41,454	$41,455 - $46.060	$46,061 - $57,575	$57,576 - $69,090	$69,091 or More
4	$27,750 or less	$27,751 - $33,300	$33,301 - $38,850	$38,851 - $49,950	$49,951 - $55,500	$55,501 - $69,375	$69,376 - $83,250	$83,251 or More
5	$32,470 or less	$32,471 - $38,964	$38,965 - $45,458	$45,459 - $58,446	$58,447 - $64,940	$64,941 - $81,175	$81,176 - $97,410	$97,411 or More
6	$37,190 or less	$37,191 - $44,628	$44,629 - $52,066	$52,067 - $66,942	$66,943 - $74,380	$74,381 - $92,975	$92,976 - $111,570	$111,571 or More
7	$41,910 or less	$41,911 - $50,292	$50,293 - $58,674	$58,675 - $75,438	$75,439 - $83,820	$83,821 - $104,775	$104,776 - $125,730	$125,731 or More
8	$46,630 or less	$46,631 - $55,956	$55,957 - $65,282	$65,283 - $83,934	$83,935 - $93,260	$93,261 - $116,575	$116,576 - $139,890	$139,891 or More

SECTION III

The patient will not be referred for Medicaid/NJ FamilyCare/other governmental medical assistance programs. (Check all that apply):

_____ monthly family income is too high

_____ patient unable to document alien status

_____ unqualified alien (entered after 8/96)

_____ patient (child) is too old

_____ not NJ resident

_____ other _____

SECTION IV (*this section to be completed by the patient*)

Health Center staff have informed me about Medicaid/NJ FamilyCare/other governmental medical assistance programs. (Check only one below)

_____ I understand that I/my dependent may qualify for one of the above referenced programs. I accept the referral and agree to apply for medical assistance.

_____ I understand that I/my dependent does not qualify for any of the above referenced programs, consequently I/my dependent is not being referred for medial assistance.

_____ I understand that I/my dependent may qualify for one of the above referenced programs. However, I am not interested in applying for any of the medical assistance programs at this time.

I attest that all information provided is truthful to the best of my knowledge.

_____ _____/_____/_____

Signature of Patient/Guardian Date

_____ _____/_____/_____

Signature of Health Center Staff Date