National Jewish Health®
Science Transforming Life®

FINANCIAL ASSISTANCE PROGRAM APPLICATION

SECTION I: APPLICANT

Last Name | Maiden Name | First Name | M.I. | SSN

Address

City | State | Zip Code | Home Phone | Work Phone

	Family Member (First and Last Name)	Dependent (Yes)	(No)	Relationship	Birthdate	SSN	Residency (Citizen)	(Legal Alien)
1.								
2.								
3.								
4.								
5.								

SECTION II: OTHER ASSISTANCE PROGRAM ELIGIBILITY

Medicaid Referral? _____ If "Yes," date denial received: _____ CHP+ Referral? _____ If "Yes," date denial received: _____

If a client is disabled, receiving cash assistance or Social Security income, is pregnant, or is under the age of 6, **a Medicaid denial is required before completing the NJFAP Application**.

CICP Eligible? _____ Eligibility Period _____ Eligible for Other State or Federal Programs? _____

SECTION III: HEALTH INSURANCE (Please attach a copy of client's health insurance policy or a copy of both sides of the client's insurance card, if available.)

I understand that NJFAP can help patients who have other medical coverage, like primary and/or secondary insurance, and that those benefits must be used up before I can use NJFAP. However, NJFAP can help me with any co-insurance, deductibles, or co-paym

Type of Policy

Name of Insurance Policy | Telephone Number:

Claim Submission Address

Policy Number | Policyholder's SSN | Group # | Effective Date | End Date

Policyholder's Name (Last, First) | Address

Policyholder's Employer Name | Address

SECTION IV: EMPLOYMENT

Name of Employer n/a | Work Phone

Address

Name of Employer | Work Phone

Address

SECTION V: OTHER INCOME

		TOTALS FROM "WORKSHEET"
1	Unearned Income	$
2	Self-Employment Income	$
3	In-Kind Income	$
4	Monthly Expense Income	$
5	Total Other Income	$

SECTION VI: CURRENT MEDICAL EXPENSES

This section allows deduction of total household medical bill payments for the current calendar year with documentation.

6 Total Current Year Medical Expenses*: $

*Must be documented by canceled checks, EOBs, or payment contracts.

SECTION VII: HOUSEHOLD EMPLOYMENT INCOME/GRAND TOTAL INCOME

	Prior 3-Month's Earnings	Annualized Total	Prior Year Tax Return Total	Employment Income Total**
Gross Employment Income	$	$	$	$

**The Employment Income Total is the greater of the Annualized Total or the Prior Year Tax Return Total.

7 **GRAND TOTAL INCOME*****: $

***If unemployed, greater of Employment Income Total -OR- Line 5.
If employed greater of Line 5 + Annualized Total -OR- Prior Year Tax Return Total.

LESS LINE 6: $

SECTION VIII: CALCULATING EQUITY IN ASSETS

	RESOURCE	Value	Balance Owed	Equity	# of Vehicles	Protection	Available Equity
8	Liquid Resources	$	$	$		$	$
9	Vehicle Equity	$	$	$		$	$
10	Real Estate	$	$	$		$	$
11	Business Equity	$	$	$		$	$

12 Total Available Equity in Resources (Lines 8+9+10+11) TOTAL RESOURCES $

13 Less Family Size Deduction Family Size X $2,500 $

14 Equity in Resources (Line 12 minus Line 13; if a negative number, then this equals zero) $

SECTION IV: TOTAL AVAILABLE ASSETS

15 Total Family Financial Status (Lines 7+14) **$**

PENALTY CLAUSE, CONFIRMATION STATEMENT, AND AUTHORIZATION FOR RELEASE OF INFORMATION

I declare that the information given on this application is true. I understand that if I make untrue statements on this application, I will no longer be accepted on NJFA

NJFAP Rating: Date:

Inpatient Copayment $

Outpatient Copayment $

Prescription Copayment: $

Notes:

Print or Type Applicant Name

Applicant Signature and Date

Print or Type Name of Individual Completing This Form

Financial Counselor's Signature and Date

Manager Signature and Date

WORKSHEET

UNEARNED INCOME CALCULATION

Payment Sources	Monthly Amount			Annualized Amount
Unemployment Compensation	$ _____	x	12	$ _____
Old Age Pension	$ _____	x	12	$ _____
Supplemental Security Income (SSI/SSDI)	$ _____	x	12	$ _____
Aid to Needy & Disabled	$ _____	x	12	$ _____
Pension Plan (name plans):	$ _____	x	12	$ _____
_____				
_____				
Commissions, bonuses, gifts, & tips	$ _____	x	12	$ _____
Alimony received	$ _____	x	12	$ _____
Income from Trusts or Annuities	$ _____	x	12	$ _____
Rental income	$ _____	x	12	$ _____
Interest income	$ _____	x	12	$ _____
Work Study Income	$ _____	x	12	$ _____
Monetary gains	$ _____	x	12	$ _____
Settlements (do not annualize)				$ _____
Tax Refunds (do not annualize)				$ _____
Net Gambling Winnings (do not annualize)				$ _____
Total Unearned Income (Transfer to Section V, Line 1)				**$** _____

SELF-EMPLOYMENT INCOME CALCULATION: BUSINESS 1

	3-Month Amount			Annualized Amount	Prior 12 Months (from tax return)
Gross Business Deposits	$	x	4	$	$
Business Expenses					
Salaries/Wages (Line 26*; excludes amounts paid to self)	$	x	4	$	$
Benefits (Line 14*)	$	x	4	$	$
Insurance (Line 15*)	$	x	4	$	$
Rent (Line 20*)	$	x	4	$	$
Cost of Goods Sold (Line 4*)	$	x	4	$	$
Mortgage Interest (Line 16a*)	$	x	4	$	$
Taxes (Line 23*)	$	x	4	$	$
Maintenance (Line 21*)	$	x	4	$	$
Utilities (Line 25*)	$	x	4	$	$
Supplies (Line 22*)	$	x	4	$	$
Professional Services (Line 17*)	$	x	4	$	$
Advertising (Line 8*)	$	x	4	$	$
Education/Licensing/Certification	$	x	4	$	$
Bad Debts (Line 9*)	$	x	4	$	$
Office Expense (Line 18*)	$	x	4	$	$
Car/Truck Expenses (Line 10*)	$	x	4	$	$
Other	$	x	4	$	$
Total Expenses	$	x	4	$	$
GROSS DEPOSITS				$	$
(TOTAL EXPENSES)				$	$
NET PROFIT			**A**	$	**B**

***All tax form references are to Federal form 1040 Schedule C. Complete one Self-Employment Income Calculation for each business owned by the applicant.**

NJFAP Total for Business 1 (Higher of A or B) (Transfer total of all businesses owned by the patient to Section V, Line 2) **$**

SELF-EMPLOYMENT INCOME CALCULATION: BUSINESS 2

	3-Month Amount			Annualized Amount	Prior 12 Months (from tax return)
Gross Business Deposits	$	x	4	$	$
Business Expenses					
Salaries/Wages (Line 26*; excludes amounts paid to self)	$	x	4	$	$
Benefits (Line 14*)	$	x	4	$	$
Insurance (Line 15*)	$	x	4	$	$
Rent (Line 20*)	$	x	4	$	$
Cost of Goods Sold (Line 4*)	$	x	4	$	$
Mortgage Interest (Line 16a*)	$	x	4	$	$
Taxes (Line 23*)	$	x	4	$	$
Maintenance (Line 21*)	$	x	4	$	$
Utilities (Line 25*)	$	x	4	$	$
Supplies (Line 22*)	$	x	4	$	$
Professional Services (Line 17*)	$	x	4	$	$
Advertising (Line 8*)	$	x	4	$	$
Education/Licensing/Certification	$	x	4	$	$
Bad Debts (Line 9*)	$	x	4	$	$
Office Expense (Line 18*)	$	x	4	$	$
Car/Truck Expenses (Line 10*)	$	x	4	$	$
Other	$	x	4	$	$
Total Expenses	$	x	4	$	$
GROSS DEPOSITS				$	$
(TOTAL EXPENSES)				$	$
NET PROFIT			**A**	$	**B**

***All tax form references are to Federal form 1040 Schedule C. Complete one Self-Employment Income Calculation for each business owned by the applicant.**

NJFAP Total for Business 2 (Higher of A or B) (Transfer total of all businesses owned by the patient to Section V, Line 2) **$**

SELF-EMPLOYMENT INCOME CALCULATION: BUSINESS 3

	3-Month Amount			Annualized Amount	Prior 12 Months (from tax return)
Gross Business Deposits	$	x	4	$	$
Business Expenses					
Salaries/Wages (Line 26*; excludes amounts paid to self)	$	x	4	$	$
Benefits (Line 14*)	$	x	4	$	$
Insurance (Line 15*)	$	x	4	$	$
Rent (Line 20*)	$	x	4	$	$
Cost of Goods Sold (Line 4*)	$	x	4	$	$
Mortgage Interest (Line 16a*)	$	x	4	$	$
Taxes (Line 23*)	$	x	4	$	$
Maintenance (Line 21*)	$	x	4	$	$
Utilities (Line 25*)	$	x	4	$	$
Supplies (Line 22*)	$	x	4	$	$
Professional Services (Line 17*)	$	x	4	$	$
Advertising (Line 8*)	$	x	4	$	$
Education/Licensing/Certification	$	x	4	$	$
Bad Debts (Line 9*)	$	x	4	$	$
Office Expense (Line 18*)	$	x	4	$	$
Car/Truck Expenses (Line 10*)	$	x	4	$	$
Other	$	x	4	$	$
Total Expenses	$	x	4	$	$
GROSS DEPOSITS				$	$
(TOTAL EXPENSES)				$	$
NET PROFIT			**A**	$	**B**

***All tax form references are to Federal form 1040 Schedule C. Complete one Self-Employment Income Calculation for each business owned by the applicant.**

NJFAP Total for Business 3 (Higher of A or B) (Transfer total of all businesses owned by the patient to Section V, Line 2) **$**

SELF-EMPLOYMENT INCOME CALCULATION: BUSINESS 4

	3-Month Amount			Annualized Amount	Prior 12 Months (from tax return)
Gross Business Deposits	$	x	4	$	$
Business Expenses					
Salaries/Wages (Line 26*; excludes amounts paid to self)	$	x	4	$	$
Benefits (Line 14*)	$	x	4	$	$
Insurance (Line 15*)	$	x	4	$	$
Rent (Line 20*)	$	x	4	$	$
Cost of Goods Sold (Line 4*)	$	x	4	$	$
Mortgage Interest (Line 16a*)	$	x	4	$	$
Taxes (Line 23*)	$	x	4	$	$
Maintenance (Line 21*)	$	x	4	$	$
Utilities (Line 25*)	$	x	4	$	$
Supplies (Line 22*)	$	x	4	$	$
Professional Services (Line 17*)	$	x	4	$	$
Advertising (Line 8*)	$	x	4	$	$
Education/Licensing/Certification	$	x	4	$	$
Bad Debts (Line 9*)	$	x	4	$	$
Office Expense (Line 18*)	$	x	4	$	$
Car/Truck Expenses (Line 10*)	$	x	4	$	$
Other	$	x	4	$	$
Total Expenses	$	x	4	$	$
GROSS DEPOSITS				$	$
(TOTAL EXPENSES)				$	$
NET PROFIT			**A**	$	**B**

***All tax form references are to Federal form 1040 Schedule C. Complete one Self-Employment Income Calculation for each business owned by the applicant.**

NJFAP Total for Business 4 (Higher of A or B) (Transfer total of all businesses owned by the patient to Section V, Line 2) **$**

IN-KIND INCOME CALCULATION

Room:

Fair Market Value of Room (if provided): $ _____

Calculated Value of Room (if no Fair Market Value is available):

Number of Household Members (per Application)	**Value per Room Value Table**
_____	$ _____

Calculated Value of Board:

Number of Household Members (per Application)	**Value per Board Value Table**
_____	$ _____

Total In-Kind Income (Transfer to Section V, Line 3)**:** $ _____

DO NOT COMPLETE THIS PART OF THE FORM IF THE CLIENT RECEIVES EMPLOYMENT INCOME AND/OR UNEARNED INCOME

Expense	Monthly Amount	Expense	Monthly Amount
Auto Insurance	$ _____	Eye exams & lenses	$ _____
Auto Loan	$ _____	Groceries (food & toiletries)**	$ _____
Auto maintenance & gas	$ _____	Loans	$ _____
Child & elderly care	$ _____	Pharmacy	$ _____
Alimony (paid)	$ _____	Physicians	$ _____
Child support (paid)	$ _____	Rent/mortgage	$ _____
Credit cards	$ _____	Telephone	$ _____
Dental	$ _____	Water, sewer, trash	$ _____
Diapers & baby formula	$ _____	Other expenses (list)	$ _____

****Do not include the value of Food Stamps or WIC**

Total $ _____ x 12 months = $ _____ (Transfer to Section V, Line 4)