

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.

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: _____ Date of Application: ____/____/____
Address: _____ Birth Date: ____/____/____

Telephone: ____ (____) _____ Family size: _____
Linked Patient Chart # _____ (include immediate family members in
Was the patient born in the US? () yes () no 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

