Children's Specialized Hospital Benefit Fund Policy - Plain Language Summary

How to Apply – CSH Benefit Fund and related application forms may be obtained/completed/submitted as follows:

- In person at any CSH registration desk/lobby.
- Request an application be mailed, by calling CSH's Patient Access Services Insurance Verification and Authorization team (PAS IV&A) at 908-233-3720 ext. 5193, Monday – Friday from 7:00AM – 6:00PM.
- Request an application by mail by writing to, Children's Specialized Hospital PAS IV&A located at 200 Somerset Street, New Brunswick, NJ 08901.
- Download the documents from the My Children's Specialized Patient & Family Portal (my.childrens-specialized.org).
- Download the application from the CSH website: https://www.childrens-specialized.org.
- Completed applications (with all documentation/information specified in the application instructions) should be returned to CSH: (1) in person at any CSH location's Registration Desk, (2) faxed to 732-258-7222, (3) emailed to cshbenefitfund@childrens-specialized.org or (4) mailed to: Children's Specialized Hospital, Attention: Patient Access Services, Insurance Verification and Authorization team at 200 Somerset Street, New Brunswick, NJ 08901.

Dear Parent/Guardian:

Thank you for choosing Children's Specialized Hospital to serve the needs of your child(ren). Enclosed you will find an application for the Children's Specialized Hospital Benefit Fund. In order to be considered, you must provide proof of being a permanent U.S. Citizen or a Legal Alien residing permanently in the state of New Jersey. Approval and the amount of assistance you may receive will be based upon a completed application, including your household income and assets. All information you provide must coincide with the dates of service for which you are applying.

We would like to extend this application to your family, even if your child has health insurance coverage. Copayment, deductibles and coinsurance are eligible under the Children's Specialized Hospital Benefit Fund.

By submitting your application, you understand that you are responsible for the accuracy of information provided, for following insurance guidelines, and for re-applying as needed. If approved, financial assistance will be valid for one year from the determined eligibility date. You are responsible for re-applying on an annual basis.

In order to consider your application, please be sure to include all necessary documents as listed on the next page. Please allow two weeks for processing once your completed application is received by Children's Specialized Hospital. We will notify you once a determination regarding your application has been made.

Sincerely,

Patient Access Services
Insurance Verification and Authorization Team

Listed below are documents that must be submitted with your Children's Specialized Hospital Benefit Fund application. Please send copies, not originals. Requested Date of Service _____

You must provide information for the *entire* month prior to the requested date of service. When applying for CSH Benefit Fund coverage for servicers already rendered, you must provide information for the month prior to the first treatment session. For example, if the patient's first treatment date was on June 1st, information must be provided for the month of May.

The following items are required and must be received to consider your application complete.

1. Income Information. Please provide:
    - If employed:
        - Two pay stubs from the month prior to requested date of service from each working member of the household
    - If self-employed:
        - Statement from certified accountant showing income from the month prior to requested date of service
        - Bank statements confirming income
    - If no family members in the household are working:
        - Two most current disability and/or unemployment checks
    - Provide legal documents for the following sources of income:
        - Social security
        - Child Support Payments
        - Alimony Payments
    - Provide checks for the following sources of income from the month prior to requested date of service:
        - Rental Income
        - Interest Income (must show source of interest)
    - All other sources of Income
2. Most recently filed Income Tax Return
3. Most current W2 Forms from each working member of the household
4. Statements from all checking and savings accounts of all members of the household from the month prior to requested date of service.
5. Proper documentation proving permanent New Jersey residency, United States Citizenship or legal Alien Residency for the patient.
    - *Examples of valid documents: Birth Certificate, Social Security Card or United States Passport, Green Card*
6. Driver's license or proper photo ID
7. Health Insurance ID Cards (If you have health insurance)
8. Proof of denial and/or eligibility of any governmental and/or private medical assistance or alternative funding source(s) that patient, family and/or guarantor is eligible if family is uninsured
9. Asset Documentation
    - This includes stocks, bonds and any other investments including property other than your primary residence. Property other than that in/on which is the guarantor/families primary residence is considered an asset and will be considered when making an eligibility determination. Assets such as (but not limited to) checking and savings, stocks and bonds other than those in designated retirement accounts, are considered in making a determination, where investment retirement plans such as (but not limited to) 401(K) or 403 (B) plans are not considered.
    - *Examples of valid documents: Most recent monthly statement of stocks, funds and bonds*

Children's Specialized Hospital Benefit
Application for Participation

Patient Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Petitioner's Name _____ Home Telephone _____

Patient Social Security Number _____ Household Size*
(WHAT EVER IS CLAIMED TO THE GOVERNMENT/IN YOUR TAX RETURN)

Requested Date of Service _____ __Friday Night Fever / Camp Pal's Paradise / Camp Kresge_____
Type of Recreation Program (Circle)

NJ Permanent Resident? **Y**es__ / No___ Legal Resident? Yes__/No__ Illegal Resident? Yes__/No__

List all members of the household, their age, and their relationship to the patient.

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

*A pregnant woman is counted as 2 household members.

Petitioner's Certification

I understand that the information submitted for consideration of the CSH Benefit Fund Program is subject to verification by Children's Specialized Hospital and/or Federal or State Governments. Willful misrepresentation of facts will make me and/or the guarantor liable for all hospital charges, and subject to civil penalties. I certify that all information provided and documentation required for processing the Children's Specialized Hospital Benefit Fund Application is true and correct, and understand that it is my responsibility to advise Children's Specialized Hospital immediately of any change in status regarding my residency, family size, income, or assets.

I and/or the guarantor agree to follow all insurance guidelines including, but not limited to, referrals, authorizations, and precertification. If I and/or the guarantor do not, I and/or the guarantor will be responsible for all charges incurred that are not covered by insurance.

I and/or the guarantor will apply, in a timely manner, for any governmental or private medical assistance or alternative funding sources that the patient, I and/or the guarantor may be eligible for and provide proof of denial or eligibility of such. I am aware that failure to provide proof of denial or acceptance will result in denial of my Children's Specialized Hospital Benefit Fund application. I am aware that my application for the Children's Specialized Hospital Benefit Fund is contingent on providing proof of denial or acceptance into such assistance in a timely manner.

Signature of Petitioner Date

Children's Specialized Hospital Benefit Fund Matrix (policy LD-21)

% of Federal Poverty Guideline	400%	410%	420%	430%	440%	450%	460%	470%	480%	490%	500%
Patient Pays:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Family Size:	Income Threshold										
1	$ 35,010	$ 35,885	$ 36,761	$ 37,636	$ 38,511	$ 39,386	$ 40,262	$ 41,137	$ 42,012	$ 42,887	$ 43,763
2	$ 47,190	$ 48,370	$ 49,550	$ 50,729	$ 51,909	$ 53,089	$ 54,269	$ 55,448	$ 56,628	$ 57,808	$ 58,988
3	$ 59,370	$ 60,854	$ 62,339	$ 63,823	$ 65,307	$ 66,791	$ 68,276	$ 69,760	$ 71,244	$ 72,728	$ 74,213
4	$ 71,550	$ 73,339	$ 75,128	$ 76,916	$ 78,705	$ 80,494	$ 82,283	$ 84,071	$ 85,860	$ 87,649	$ 89,438
5	$ 83,730	$ 85,823	$ 87,917	$ 90,010	$ 92,103	$ 94,196	$ 96,290	$ 98,383	$ 100,476	$ 102,569	$ 104,663
6	$ 95,910	$ 98,308	$ 100,706	$ 103,103	$ 105,501	$ 107,899	$ 110,297	$ 112,694	$ 115,092	$ 117,490	$ 119,888
7	$ 104,790	$ 107,410	$ 110,030	$ 112,649	$ 115,269	$ 117,889	$ 120,509	$ 123,128	$ 125,748	$ 128,368	$ 130,988
8	$ 116,490	$ 119,402	$ 122,315	$ 125,227	$ 128,139	$ 131,051	$ 133,964	$ 136,876	$ 139,788	$ 142,700	$ 145,613