All sections of the Health Care Assistance Application must be completed as follows:

Member fills in:

Statement of Medical need
All personal information.
Agency information (service provider)
Financial data (with supporting documentation)
Authorization Release Form on back of application

Member provides:

Medical certification from a doctor for the need for the care
Copy of the contract with the projected cost breakdown

NOTE: ONCE COMPLETED GIVE THE INITIAL APPLICATION TO THE LOCAL RELIEF ASSOCIATION. RENEWALS GO DIRECTLY TO THE NJSFA STATE OFFICE.

Local Relief Association:

Date, Association Number, Company Number, Line Number, Relief Association name and County
Local Officers sign once it is determined this level of assistance is needed. **(NOTE: This should not wait for a regularly scheduled meeting.)**
Forward signed application to New Jersey State Firemen's Association State Office

The New Jersey State Firemen's Association will notify the Local Relief Association and the members on the approval or denial of the application.

Approved Application:

The member will scan and email the monthly bill and proof of payment to HealthCare@njsfa.com
or fax copies to 732-938-2580.
or mail copies to:

New Jersey State Firemen's Association
Attn: Health Care
1711 Route 34 South
Wall Township, NJ 07727-3934

The New Jersey State Firemen's Association will mail the **reimbursement** check to the member. Payments are made after receiving all the bills (and proof of payment) for a given month (net of any other payments). Only one Check will be made out from the State Office for each monthly reimbursement.

REFER TO THE LAST THREE PAGES FOR THE RULES AND GUIDELINES FOR FURTURE ASSISTANCE AND INSTRUCTIONS IN COMPLETING THIS APPLICATION

Assoc#/Company #/Line #_____ Date: _____

Health Care Assistance Application

The _____Firemen's Relief Assn. of _____county wish to have financial assistance for Health Care considered for their member listed below.

Member Name_____DOB_____

Reimbursement/Renewal Mailing Address _____

Applicant Phone_____ Cell Phone_____ Does applicant live alone? Yes / No

MUST provide the medical statement of need and a medical certification letter from the doctor for the services: i.e. Applicant needs assistance with personal hygiene, transferring, walking.

Signature of Applicant _____
All information provided on this application is true and accurate to the best of my knowledge.

This program does not cover various types of services such as Assisted Living facilities or senior living type facilities, maid service, meal preparation companies, or any similar types of service. It is for the direct medical care of the individual in need.

The applicant needs ☐In Home Care ☐Memory Care ☐Nursing Home ☐ Adult Day Care

A copy of the Agency contract with pricing MUST be included.

Name of Agency providing care _____
Agency Address_____
Agency must be licensed in the state where care will be provided. License #_____

Projected cost for care of applicant per month $_____
Is the applicant receiving any funds to cover any portion of this expense? Yes / No Amount $_____
Medicare ☐ Long Term Insurance ☐ Medicare Supplement ☐ VA Assistance ☐
Name of other funding source/s _____ Net Balance $_____
Requested monthly amount of assistance $_____

Local Relief Association Signoffs

It has come to the attention of the Trustees and Representatives of the above listed Relief Association that our member would benefit from the use of the Health Care Assistance Program. We have reviewed the information provided to us and request the NJSFA consider this application for final approval. **(Note: This does not need to wait for a regularly scheduled meeting)**

Signatures: President _____Secretary _____Treasurer _____

NJSFA State Office Advisory Committee

Meeting Date: _____ Approved / Denied Projected Amount _____

Chairman _____

Assoc#/Company #/Line #_____ **Form 114 (REV 2/25)**

FINANCIAL DATA

To process your application, the following information is needed. The information supplied is strictly confidential. Your cooperation is appreciated to expedite acceptance. Name of person who will handle financial matters. This person must also sign this questionnaire.

Name:_____Relationship:_____

Address: _____

Telephone Numbers: Home: _____ Cell: _____

MONTHLY INCOME OF APPLICANT: (SUPPORTING DOCUMENTATION TO BE INCLUDED)

SALARY	$_____	RENTAL INCOME	$_____
SOCIAL SECURITY	$_____	INVESTMENTS/ TRUSTS	$_____
PENSION/ ANNUITIES	$_____	VETERAN'S BENEFITS	$_____
IRA	$_____	ALIMONY	$_____

TOTAL MONTHLY INCOME $_____

HOUSEHOLD ASSETS:

BANK ACCOUNTS:

_____ $ _____
_____ $ _____
_____ $ _____

SECURITIES (STOCKS / BONDS)

_____ $ _____

REAL ESTATE: Address(s) _____
Is anyone currently living in this house? ☐ Yes ☐ No (Current Market Value) $_____

If Yes, Name _____ Relationship _____

Is house jointly owned? ☐ Yes ☐ No

If Yes, Name _____ Relationship _____

I hereby affirm that, to the best of my knowledge, the information provided is accurate and complete. I understand that NJSFA will rely upon the accuracy and completeness of the above financial information in deciding.

Signature_____Date_____

On Behalf of_____ Relationship_____

Assoc#/Company #/Line#_____

Form 114 (REV 2/25)

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize the New Jersey State Firemen's Association to receive and/or release information as necessary, to obtain appropriate services for:

_____ _____

Applicant's Name (Printed) Email Address

_____ _____

Guardian's Name (Printed) Email Address

_____ _____

Applicant/Guardian's Signature Date

Name, Phone Number & Email of POA

_____ _____ _____

Name Phone Email Address

I give New Jersey State Firemen's Association permission to release information to the following family/friends.

_____ _____ _____

Name Relationship Email Address

_____ _____ _____

Name Relationship Email Address

_____ _____ _____

Name Relationship Email Address

- **Applications will be accepted on the date they are stamped into the state office.**
  - **If the application is incomplete and/or missing items, the applicant will be advised either by email or letter and have 30 days to complete the application.**
  - **Applications once completed will go to the Advisory Board for final approval at the scheduled meetings.**

- **Applicants will have 60 days from the date of service to turn in all bills and proof of payment to the state office for reimbursement. Bills more than 60 days old will not be reimbursed.**
  - **Reimbursements are made after receiving all the bills and proof of payment for a given month (net of any other payments). Only one Check will be made out from the State Office for each monthly reimbursement.**

RULES AND GUIDELINES GOVERNING HEALTH CARE ASSISTANCE FORM 114

Introduction

These guidelines are provided to assist you and the Local Association with the investigation and completion of the application for Health Care Relief Form # 114. It is a goal of The New Jersey State Firemen's Association to assist all its members **who need at home care, or care in a nearby facility**, for as long as possible so they can be close to their family and brother and sister firefighters. Should the level of care be so great that at home care is not possible, assistance **will still be considered for care in long-term care facilities.** This is a reimbursement program. The member will be reimbursed for the medical care cost of the care provided up to the dollar amount set by the Executive Committee.

When to use this assistance form

The use of this form should be considered when any member of a Local Relief Association has information that another member in good standing of this Association:

Needs care beyond that which they can provide for themselves.
Needs care beyond that which a spouse, family member, or friend can or will provide.

Things to consider.

The member needs help attending to their personal hygiene and care, changing bandages, or attending to other physical or medical needs for themselves. The spouse or other family member works or has obligations during the day and member cannot be left alone in residence. Does the member have any insurance that will cover any or all the cost for the necessary services? How many hours a day and or days of the week does the member need assistance?

The Health Care Assistance Reimbursement Program

The program is available to all active or qualified members of this Association regardless of what state they retire to or decide to live in within the continental United States.

To obtain an application for this program, contact your Local Relief Association Officers. You may also download a copy from our website www.njsfa.com from the "Forms" tab. All first-time applications, on Form 114, are to be filled out completely and submitted to your Local Relief Association Secretary. Once the application is approved at the local level and the Local Association Officers sign the application, it is sent to the NJSFA State Office for final approval. Reimbursements will begin to the member once the NJSFA Advisory Committee has given final approval. **All required information and documentation must be submitted before approval will be considered.** Reimbursement begins with the month that the State Office approval is given and will be done after copies of the full calendar month's invoices and copies of proof of payment have been submitted to the NJSFA Field Examiner. Copies of invoices and copies of proof of payment can be mailed in, faxed in, or emailed to HealthCare@njsfa.com. Facility and Care Company licensing will be confirmed by the NJSFA State office. Social Daycare programs will be approved on a case-by-case basis by the NJSFA Advisory Committee. The decision of the Advisory Committee is final.

All applications are valid for one year and each application will need to be resubmitted (renewed) annually from date of original approval, or if the reason for the original application changes. If the Local Association denies the applicant, please contact the State Office for the appeal process at (800) 852-0137. **All Renewals will be handled by the State Office.** These funds may not be used to offset any payment or costs for guests admitted to the New Jersey Firemen's Home but can be used while a member is awaiting admittance or on a waiting list. Once a member becomes eligible for Medicaid this benefit will cease.

This reimbursement program is not available to Firefighters that are admitted or residing in the New Jersey Firemen's Home located in Boonton, NJ. The New Jersey Firemen's home is fully funded from the same property insurance tax that funds the New Jersey Firemen's Association and the Local Firemen's Relief Associations.

Things to consider when assessing need for care:

- **The Member is having difficulty caring for themself.**
- **Personal hygiene needs are not being met.**
- **Member is not capable of taking medications as prescribed.**
- **Care by the spouse and family can no longer meet the needs of the member.**
- **The spouse or family needs respite for their own personal obligations and the applicant cannot be medically left alone.**
- **Members cannot be left alone while spouse or family members work or are away from the home.**

This program does not cover various types of services such as Assisted Living facilities or senior living type facilities, lawn care, property maintenance, maid service, meal preparation companies, or any similar types of service. It is for the direct medical care of the individual in need.

Should there still be additional financial need, Regular Relief can still be applied for even if the member is enrolled in this program. Need must still be demonstrated and fully documented for Relief to be awarded.

The program is designed to provide reimbursement to members of this Association for in home health care and nursing home levels of medical care that have not been covered by insurance or other existing medical reimbursement programs. It covers in-home care that is provided by certified employees working and billing through a licensed health care provider in the state where the care is being provided.

Nursing Homes, In Home Care, and Adult Medical Daycare Facilities are all types of care our members may need at some point when they are no longer able to care for themselves or their families need additional assistance to help with that care.

The Officers and Executive Committee Members of the New Jersey State Firemen's Association recognize the need to aid those members of the Association who are no longer able to perform normal daily activities for themselves.

Keeping in mind that spouses, family members, neighbors, and brother and sister Firefighters wish to remain together during these times, we will all work together to make sure the best care is available to the Firefighters who took care of so many others during their time of service.

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If you suspect abuse by any caregiver while receiving in home care or care in any nursing home facility, the New Jersey Division of Consumer Affairs can provide a hidden camera to help verify suspected abuse. The *Safe Care Cam Program* is available to any New Jersey Resident and additional information, or contact can be made by calling them directly at 973-504-6375 or visiting their website at www.njconsumeraffairs.gov .

Benefit Reimbursement Up-To Levels **Form 114 (REV 2/25)**

Based on submitted bills and proof of payment

Home Care, Adult day Care

a. 1 month to 11 months qualifying time – reimbursement up to $750.00/month
b. 12 months to 23 months qualifying time – reimbursement up to $1,500.00/month
c. 24 months to 35 months qualifying time – reimbursement up to $2,250.00/month
d. 36 months to 47 months qualifying time – reimbursement up to $3,000.00/month
e. 48 months to 59 months qualifying time – reimbursement up to $3,750.00/month
f. 60 months to 71 months qualifying time – reimbursement up to $4,500.00/month
g. 72 months to 83 months qualifying time – reimbursement up to $5,250.00/month
h. 84 months and greater (fully qualified) – reimbursement up to $6,000.00/month

Nursing Home, Long Term Care Facility – 24/7 care in-facility

a. 1 month to 11 months qualifying time – reimbursement up to $1,500.00/month
b. 12 months to 23 months qualifying time – reimbursement up to $3,000.00/month
c. 24 months to 35 months qualifying time – reimbursement up to $4,500.00/month
d. 36 months to 47 months qualifying time – reimbursement up to $6,000.00/month
e. 48 months to 59 months qualifying time – reimbursement up to $7,500.00/month
f. 60 months to 71 months qualifying time – reimbursement up to $9,000.00/month
g. 72 months to 83 months qualifying time – reimbursement up to $10,500.00/month
h. 84 months and greater (fully qualified) – reimbursement up to $12,000.00/month