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 help aid with care to all its members (or Qualified Spouses) **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, relief assistance **will still be considered for care in assisted living or long-term care facilities.** This is a reimbursement program. The member or spouse will be reimbursed for the net 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 (or Qualified Spouse) 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 (or qualified spouse) 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 (or qualified spouse) 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 the member needs assistance.

All applications are valid for one year and each application will need to be resubmitted annually from date of original approval, or if the reason for the original application changes. **This is done by the state office.**

If the local association denies the applicant, please contact the state office for the appeal process at (800)-852-0137.

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.

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

Local Relief Association fills in:

Association Number, Company Number and Line Number
Date
Relief Association and County

Member fills in:

Statement of Medical need (no financial information is required)
All personal information
Agency information
Projected cost

Member fills in:

Authorization Release Form on back of application

NOTE: ONCE COMPLETED GIVE TO THE LOCAL RELIEF ASSOCIATION

Local Relief Association fills in:

Local Officers Sign once it is determined this level of assistance is needed.
Forward to New Jersey State Firemen's Association

The New Jersey State Firemen's Association will notify the Local Relief Association and the member (or Qualified Spouse) on the approval or denial of the application.

APPROVED APPLICATION:

The member will mail the monthly bill and proof of payment to the:

New Jersey State Firemen's Association
1711 Route 34 South
Wall Township N.J. 07727-3934
Or scan and e mail to
localreports@njsfa.com

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

_____ **Health Care Assistance Application**

Assoc. No. - Comp. No - Line No.

Application is for: Firefighter ☐ Spouse/Surviving Spouse ☐ Application Date_____

The _____ Firemen's Relief Assn. of _____County wish to have financial assistance for Health Care considered for their member or member's spouse listed below.

Member Name_____ DOB_____ Male / Female Married / Widow(er) / Single

Spouse Name_____ DOB_____ Male / Female Married / Widow(er)

If benefit is for the surviving spouse of a "Qualified" Firefighter, has the surviving spouse remarried? Yes / No

Applicant Address _____ Town_____ State_____ Zip_____

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

Name of current care giver _____ Relationship to applicant_____

Reimbursement/Renewal Mailing Address _____

Please provide the medical statement of need: i.e. Applicant needs assistance with personal hygiene, transferring, walking.

_____

_____

Signature of Applicant _____ **(see reverse side for additional required information)**

All information provided on this application is true and accurate to the best of my knowledge. The applicant is currently receiving: ☐ No care ☐ In Home Care ☐ Assisted Living Facility ☐ Nursing Home/Memory Care ☐ Adult Day Care

The applicant is in need of ☐ In Home Care ☐ Assisted Living Facility ☐ Nursing Home/Memory Care ☐ Adult Day Care

Has applicant applied for or is receiving Medicaid? Yes/ No If no, projected date member will be eligible _____

Name of Agency providing care _____

Agency Address_____ Town_____ State_____ Zip_____

Agency Contact Person_____ Phone_____

Agency must be licensed in the state where care will be provided. License #_____

Projected cost for care of applicant per month $_____

Is applicant receiving any funds to cover any portion of this expense? Yes / No Amount funded $_____

Name of other funding source _____ Net Balance $_____

Requested monthly amount of assistance $_____

It has come to the attention of the Trustees and Representatives of the above listed Relief Association that our member and or Spouse would benefit from the use of the Health Care Assistance Program. We have reviewed the information provided 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 Board Meeting Date_____ Approved / Denied Amount _____

Chairman _____

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	Phone Number
_____	_____	_____	_____
Name	Relationship	Email Address	Phone Number
_____	_____	_____	_____
Name	Relationship	Email Address	Phone Number