



COMMUNITY HEALTH CENTER

Visiting Nurse Association of Central Jersey

HRSA Medical Assistance Referral Form 2026

Patient Name: _____ DOB Patient: ____/____/____ Age of Patient: _____

SECTION I:

Annual Family Income \$ _____ Family Size: _____
Divided by 12 (Monthly Family Income) \$ _____

SECTION II (circle the box that applies; if no box applies, go to SECTION III)

HRSA Medical Sliding Fee Discount 2026								
Service*	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Full Fee
Medical	\$ 30.00	\$ 35.00	\$ 40.00	\$ 45.00	\$ 50.00	\$ 55.00	\$ 60.00	NO DISCOUNT
Specialist <i>(Chiropractor, Psych APN, Nutrition, and Podiatry)</i>	\$ 40.00	\$ 45.00	\$ 50.00	\$ 55.00	\$ 60.00	\$ 65.00	\$ 70.00	
Prenatal	\$ 20.00	\$ 25.00	\$ 30.00	\$ 35.00	\$ 40.00	\$ 45.00	\$ 50.00	
Behavioral Health	\$ 10.00	\$ 15.00	\$ 20.00	\$ 25.00	\$ 30.00	\$ 35.00	\$ 40.00	
GYN Procedure	\$ 75.00	\$ 85.00	\$ 95.00	\$ 105.00	\$ 115.00	\$ 125.00	\$ 135.00	
Household Size**	Household Income							
	0% - 100%	>100% - 120%	>120% - 135%	>135% - 150%	>150% - 175%	>175% - 185%	>185% - 200%	>200%
1	\$0	\$15,961	\$19,153	\$21,547	\$23,941	\$27,931	\$29,527	\$31,921
	\$15,960	\$19,152	\$21,546	\$23,940	\$27,930	\$29,526	\$31,920	&above
2	\$0	\$21,641	\$25,969	\$29,215	\$32,461	\$37,871	\$40,035	\$43,281
	\$21,640	\$25,968	\$29,214	\$32,460	\$37,870	\$40,034	\$43,280	&above
3	\$0	\$27,321	\$32,785	\$36,883	\$40,981	\$47,811	\$50,543	\$54,641
	\$27,320	\$32,784	\$36,882	\$40,980	\$47,810	\$50,542	\$54,640	&above
4	\$0	\$33,001	\$39,601	\$44,551	\$49,501	\$57,751	\$61,051	\$66,001
	\$33,000	\$39,600	\$44,550	\$49,500	\$57,750	\$61,050	\$66,000	&above
5	\$0	\$38,681	\$46,417	\$52,219	\$58,021	\$67,691	\$71,559	\$77,361
	\$38,680	\$46,416	\$52,218	\$58,020	\$67,690	\$71,558	\$77,360	&above
6	\$0	\$44,361	\$53,233	\$59,887	\$66,541	\$77,631	\$82,067	\$88,721
	\$44,360	\$53,232	\$59,886	\$66,540	\$77,630	\$82,066	\$88,720	&above
7	\$0	\$50,041	\$60,049	\$67,555	\$75,061	\$87,571	\$92,575	\$100,081
	\$50,040	\$60,048	\$67,554	\$75,060	\$87,570	\$92,574	\$100,080	&above
8	\$0	\$55,721	\$66,865	\$75,223	\$83,581	\$97,511	\$103,083	\$111,441
	\$55,720	\$66,864	\$75,222	\$83,580	\$97,510	\$103,082	\$111,440	&above

*The above charges are per visit and may not include lab fees, medications, or contraceptives. Fees will be communicated to you prior to being charged.

**For families/households with greater than 8 people, please refer to the Department of Health and Human Services Federal Poverty Guidelines detailed data.

SECTION III

The patient will not be referred for Medicaid/NJ Family Care/ACA or other governmental medical assistance programs because (check all that apply):

- Monthly family income is too high
- Patient (child) is too old
- Patient unable to document alien status
- Patient does not live in NJ
- Other: _____

SECTION IV (this section is to be completed by the patient)

Health Center staff has informed me about Medicaid/NJ Family Care/other governmental medical assistance programs. (Check only one below)

- I understand that I/my dependent may qualify for one of the above referenced programs. I accept the referral and agree to apply for medical assistance.
- I understand that I/my dependent does not qualify for any of the above referenced programs, consequently I/my dependent is not being referred for medical assistance.
- I understand that I/my dependent may qualify for one of the above referenced programs. However, I am not interested in applying for any of the medical assistance programs at this time and understand I will be responsible for all fees related to my care and/or that of my dependent(s).

Signature of Patient/Guardian _____

Date ____/____/____

Signature of Health Center Staff _____

Date ____/____/____