



COMMUNITY HEALTH CENTER

Visiting Nurse Association of Central Jersey

LOA 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)

LOA Medical Sliding Fee Discount 2026							
Service*	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Full Fee
Medical	\$ 25.00	\$ 30.00	\$ 35.00	\$ 40.00	\$ 45.00	\$ 50.00	No Discount
Behavioral Health	\$ -	\$ 5.00	\$ 10.00	\$ 15.00	\$ 20.00	\$ 25.00	
Prenatal	\$ 10.00	\$ 15.00	\$ 20.00	\$ 25.00	\$ 30.00	\$ 35.00	
Household Size**	Household Income						
	0% - 100%	>100% - 133%	>133% - 150%	>150% - 175%	>175% - 200%	>200% - 250%	>250%
1	\$0	\$15,961	\$21,228	\$23,941	\$27,931	\$31,921	\$39,901
	\$15,960	\$21,227	\$23,940	\$27,930	\$31,920	\$39,900	&above
2	\$0	\$21,641	\$28,782	\$32,461	\$37,871	\$43,281	\$54,101
	\$21,640	\$28,781	\$32,460	\$37,870	\$43,280	\$54,100	&above
3	\$0	\$27,321	\$36,337	\$40,981	\$47,811	\$54,641	\$68,301
	\$27,320	\$36,336	\$40,980	\$47,810	\$54,640	\$68,300	&above
4	\$0	\$33,001	\$43,891	\$49,501	\$57,751	\$66,001	\$82,501
	\$33,000	\$43,890	\$49,500	\$57,750	\$66,000	\$82,500	&above
5	\$0	\$38,681	\$51,445	\$58,021	\$67,691	\$77,361	\$96,701
	\$38,680	\$51,444	\$58,020	\$67,690	\$77,360	\$96,700	&above
6	\$0	\$44,361	\$59,000	\$66,541	\$77,631	\$88,721	\$110,901
	\$44,360	\$59,000	\$66,540	\$77,630	\$88,720	\$110,900	&above
7	\$0	\$50,041	\$66,554	\$75,061	\$87,571	\$100,081	\$125,101
	\$50,040	\$66,553	\$75,060	\$87,570	\$100,080	\$125,100	&above
8	\$0	\$55,721	\$74,109	\$83,581	\$97,511	\$111,441	\$139,301
	\$55,720	\$74,108	\$83,580	\$97,510	\$111,440	\$139,300	&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 ____/____/____