



# COMMUNITY HEALTH CENTER

Visiting Nurse Association of Central Jersey

## Ryan White 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)

Ryan White Sliding Fee Discount 2026								
Service*	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Full Fee	Full Fee
Ryan White Visit	\$ -	\$ 20.00	\$ 25.00	\$ 30.00	\$ 35.00	\$ 40.00	\$ 50.00	No Discount
Household Size**	Household Income							
	0% - 100%	>100% - 133%	>133% - 150%	>150% - 175%	>175% - 200%	>200% - 250%	>250%	>500%
1	\$0	\$15,961	\$21,228	\$23,941	\$27,931	\$31,921	\$39,901	\$79,801
	\$15,960	\$21,227	\$23,940	\$27,930	\$31,920	\$39,900	\$79,800	&above

### 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