Beacon Light Fund
MGNJA, Inc.
P.O. Box 302
Annandale, NJ 08801
(201) 563-3501
www.beaconlightfund.org

DATE _____

APPLICATION FOR ASSISTANCE

Check List for Items to Include with Submission

___ This Application Completed

___ Photo ID of Applicant (copy)

___ Current Health Status Verification (copy)

___ Original Bill to be Paid

___ Bank Statement or Income statement (copy)

___ Social Security Card (copy)

___ Any Backup Information (if necessary)

NAME _____

ADDRESS _____

_____

TELEPHONE(s) _____

EMAIL ADDRESS _____

SOCIAL SECURITY NO. _____

Have you Applied for Assistance before: ☐ **YES** ☐ **NO**

If YES When is the Approx Date of Last Assistance _____

CURRENT ESTIMATED INCOME _____ **as of Date**: _____

WHAT ASSISTANCE IS REQUIRED

_____

_____

_____

By my signature below I hereby release and hold harmless Miss Gay New Jersey Association, Inc., Beacon Light Fund, their agents, servants, and employees from Liability and or responsibility what so ever resulting from, associated with or arising out of my participation in this fund. I hereby allow, Miss Gay New Jersey Association the right to verify my current health status in order to participate in the fund. Without this information verified funds can not be distributed. This by no means will be shared with anyone. Your privacy is the utmost importance to the organization.

_____ _____

APPLICANT'S PRINTED NAME APPLICANT'S SIGNATURE

Check each that apply:

☐ Wish to be included in future Beacon Light Events ☐ Want counselors to check in with you once in awhile

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To be filled out by Beacon Light

Intake Counselor's Name: _____ Signature: _____

Income Verified _____ Documentation Attached _____ Bill Attached _____ Application Complete _____

Assistance Package Completed / Paid / Sent _____ Date Received _____

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: Beacon Light Fund, MGNJA, Inc
Name of Healthcare Provider/Physician/Facility/Medicare Contractor
PO BOX 302
Annandale, NJ 08801

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- All physical, occupational and rehab requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All employment, personnel or wage records.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: Financial Assistance

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508 Continued

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Officers of the Beacon Light Fund, MGNJA, Inc.
Name of Representative

Records Requestors, Assistance Counselors
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(vi)) Date

_____

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR §164.508(c)(1)(iv))

_____ _____

Witness Signature Date

Additional Assistance Resources

Universal Service Fund Program (USF, 1-866-240-1347)
(New Jersey Department of Community Affairs) USF provides low-income customers a payment plan to help lower the monthly cost for electric service. Participants pay a maximum percentage of their total household income for electric and natural gas. USF is a statewide program administered by the New Jersey Department of Human Services. Fresh Start, the debt forgiveness component of USF, provides a one-time opportunity to eliminate pre-program account arrearages. There are household income and other program qualification requirements.

New Jersey Statewide Heating Assistance and Referral for Energy Services (New Jersey SHARES, www.njshares.org or 1-866-657-4273)
New Jersey SHARES is a non-profit corporation organized to provide assistance to individuals and families living in New Jersey who are in need of temporary help in paying their energy bills. This program is designed to assist customers who would otherwise have no means of assistance. A history of good faith utility payments is considered for eligibility.

New Jersey Social Services – Dial 211
http://www.state.nj.us/humanservices/

Life line Across America – Contact your local utility provider and reference
http://www.lifeline.gov/
"Lifeline Across America" is a federal/state working group that includes the Federal Communications Commission, the National Association of Regulatory Utility Commissioners, and the National Association of State Utility Consumer Advocates. Our mission is to provide information and resources regarding the Lifeline and Link-Up programs, which provide discounts to low-income consumers for telephone installation and monthly bills.

Hyacinth AID Foundation – 800-433-0254
http://www.hyacinth.org/hyacinth/home/index.jsp
Welcome to Hyacinth AIDS Foundation, the first and largest AIDS service organization in New Jersey. Founded in 1985, we are a not-for-profit, tax-exempt agency. We provide client services in six regional offices as well as several statewide services... that include individual client advocacy as well as hotline counseling for prevention, care and treatment, service referrals, professional and community education workshops, legal services and public policy advocacy.

Norwescap – 908-454-7000 http://www.norwescap.org/
Dedicated to housing development, energy conservation, child care, Head Start, volunteerism, nutrition, child care referral, outreach, information & referral, food bank, case management, and Utility assistance programs in Hunterdon, Warren, Somerset Counties.

Energy Assistance via Norwescap – 908-454-4778

NY Office of Temporary and Disability Assistance - http://otda.ny.gov/

NY Rental Assistance Programs -
http://www.hud.gov/local/ny/renting/assistanceprograms.cfm

NY Emergency Assistance – NYC Affordable Housing Resource Center -
http://www.nyc.gov/html/housinginfo/html/em_assist/emergency_assistance.shtml/

NY HRA – Temporary Cash Assistance -
http://www.nyc.gov/html/hra/html/directory/cash.shtml

JOE-4-OIL -
http://www.citizensenergy.com/english/pages/33/how-to-apply

Applicants must call 1-877-JOE-4-OIL (1-877-563-4645) to apply for the program. Applications are not available online.

- A customer service representative will take some preliminary information over the phone. The applicant will receive an Income Verification Form by mail.
- The applicant must fill in their income, sign and return this form.
- For qualified applicants, a voucher for oil will be sent to their home.
- The customer is responsible for contacting their approved dealer and scheduling a delivery.
- Our Program only approves a one time delivery of 100 gallons per household.

PLEASE NOTE - **The application process for JOE-4-OIL takes 4-5 weeks for this service as it is not an emergency assistance program.**