

FAMILY CARE MEDICAID

BERGEN COUNTY BOARD OF SOCIAL SERVICES
218 STATE ROUTE 17 NORTH ROCHELLE PARK, NJ 07662-3300



Family Care Medicaid

Required Verifications

In order to apply for Family Care Medicaid you must complete the attached Customer Information Fact Sheet and the Application (NJFC-APP-0314). Once these forms are completed, you must return them to the Bergen County Board of Social Services along with all of the following verifications that apply to you:

PLEASE SEND COPIES ONLY (NO ORIGINALS).

For each person included in the application:

Proof of Legal Status - Birth Certificate, United States Passport, Naturalization Certificate, Alien Registration Card (front and back), or I-94.

Proof of Identification – *Photo ID Required for Each Person Included on the Application* - Driver's License, Passport, Alien Registration Card, School ID. If you have a child under the age of 19 without ID, complete the attached "Certificate of Identification" Form.

Proof of Income – Tax return for the most recent year (If you are claimed on someone else's tax return, you must provide a copy of their most recent return). If you did not file a tax return, or if the tax return is not representative of your current income, you may submit alternate verifications including: paystubs, employer letter, profit/loss statement, signed letter of support or contribution from outside source, Proof of: Social Security income, Disability income, unemployment compensation, pension income, alimony, or any other income.

Proof of Other Health Insurance – Health Insurance card for each person included on the application that has other health care coverage.

FAMILY CARE MEDICAID

Customer Information Sheet



Please complete the following information/ Por favor, complete la siguiente información:

Last Name/Apellido _____ First Name/Nombre _____ MI/Inicial _____ Sex -M -F

Social Security Number/Número de Seguro Social _____ Date of Birth/ Fecha de Nacimiento _____

Email: _____ Marital Status/ Estado Civil _____ Race/Raza* _____

Address/Dirección _____

City/Ciudad _____ Zip Code/Código Postal _____

Telephone/Teléfonos _____

Home/Casa _____ Cellular _____ Other/Otro _____

US Citizen/Ciudadano EE. UU. -Yes/Si -No If no, date of entry/Si no eres ciudadano de EE. UU., fecha de entrada al país _____

Education Level/ Nivel de Educación _____ Homeless/ Sin Hogar? -Yes/Si -No

Family Composition - Please provide the information requested below for each person currently residing with you.

Composición Familiar - Por favor, proporcione la información solicitada a continuación para cada persona que reside con usted.

First Name/Nombre	Last Name/Apellido	DOB Fecha de Nacimiento	Social Security Number Numero de Seguro Social	Relationship Parentezco	Citizenship/Alien Status Estatus Legal	Include in application? Incluir en aplicación?
						<input type="checkbox"/> -Yes/Si <input type="checkbox"/> -No
						<input type="checkbox"/> -Yes/Si <input type="checkbox"/> -No
						<input type="checkbox"/> -Yes/Si <input type="checkbox"/> -No
						<input type="checkbox"/> -Yes/Si <input type="checkbox"/> -No
						<input type="checkbox"/> -Yes/Si <input type="checkbox"/> -No
						<input type="checkbox"/> -Yes/Si <input type="checkbox"/> -No

PLEASE COMPLETE REVERSE SIDE • POR FAVOR COMPLETE PAGINA DE ATRÁS

*** In order to be eligible for money (TANF), you must cooperate with the child support program. Unless domestic violence is involved, this agency will be seeking support from all parents that do not live in your home. If you are not interested in seeking support, please tell the receptionist immediately.

*** Para ser elegible para recibir dinero (TANF), usted debe cooperar con el programa de manutención de niños. A menos que se trata de la violencia doméstica, esta agencia buscará imponer el pago de manutención a todos los padres que no viven en su casa. Si usted no está interesado en imponer el pago de manutención, por favor, informe a la recepcionista inmediatamente.

*I=American Indian/ Indio Americano,
A=Asian/ Asiático, W=White/ Blanco,
B=Black or African American/Negro o
afroamericano,
H=Native Hawaiian or other Pacific
Islander/ Nativo de Hawai u otra isla
del Pacifico,
O=American Indian or Alaska Native
and Asian/ Indio Americano o nativo
de Alaska o Asia

ML= Married living together
/Casados viven juntos
MS= Married Separated
/Casados viven separados
S=Single/Soltero,
W=Widow/Viudo,
D=Divorced/Divorciado



Affordable health coverage. Quality care.

1-800-701-0710 (TTY 1-800-701-0720)

Rights and Responsibilities

- I promise that I have answered all questions on this application truthfully.
- I understand that I may be asked for other information by NJ FamilyCare or the HMO.
- I give permission to NJ FamilyCare to talk to employers and State agencies to make sure that the income information I have given is correct (NJ FamilyCare may check Social Security, wage benefits, unemployment benefits and other income sources).
- I understand that NJ FamilyCare may use my income information only for this application.
- I understand that NJ FamilyCare will obey federal and State laws when they review my application.
- I understand that I have the right to ask for a review of any decision NJ FamilyCare makes about my application.
- I understand that it is a crime if I, or anyone else who is mentioned on this application, provides information that is not true and, that I can be punished under federal and state laws for knowingly providing false information.
- I understand that NJ FamilyCare can tell whoever helped me with the application what is happening to my application.
- I understand that after NJ FamilyCare reviews my application, my family will be enrolled in the program for which they qualify.
- I understand that if my family qualifies for NJ FamilyCare the Commissioner of Human Services may have the right to any payments for medical care from a third party (such as an insurance company or legal settlement).
- I understand that I must fill out a Renewal Application for this health insurance each year.
- I understand that I must tell NJ FamilyCare immediately about any changes in my information, such as a change in income or a change of address. I know that I must call 1-800-701-0710 (TTY 1-800-701-0720) to report any changes.
- I understand that if I do not report changes I may lose my benefits and have to pay for the benefits I have used, with interest and penalties.
- I understand that the information which I have given is private and will be given only to the HMO, the Health Benefits Coordinator and NJ FamilyCare.
- I understand that because I have joined an HMO, I must follow the rules for obtaining health care from the HMO.
- I understand that I must let my HMO and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my HMO.
- I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist.
- I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the HMO as soon as possible after I, or the family member, go to the hospital.
- I understand that I must keep any medical appointment I have scheduled with a doctor and, if I cannot, I must call the doctor's office to cancel the appointment.
- I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the HMO, I may have to pay for that doctor's services because NJ FamilyCare will not pay for the unapproved service or visit.
- I understand that I may change to another HMO and that I can call the Health Benefits Coordinator to help me do that.
- I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the HMO and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the HMO.

NJ FamilyCare does not discriminate against anyone because of race, age, color, religion, sex, national origin, marital status, disability, or political belief.

NJFC-RR-0905

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW



Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP), known as NJ FamilyCare
- Private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can help pay your premiums for health coverage



Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit njfamilycare.org.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



Apply faster online

Apply faster online at njfamilycare.org.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to njfamilycare.org.



What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit njfamilycare.org or call **1-800-701-0710**. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- **Online:** njfamilycare.org
- **Phone:** Call our Help Center at **1-800-701-0710**.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-800-701-0710** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-701-0710**.



NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number () -		15. Other phone number () -	
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?			

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. **If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.**

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.



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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix	2. Relationship to you? SELF
---	--

3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
-------------------------------	--

5. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? Yes No a. **If yes,** how many babies are expected during this pregnancy? _____ Due Date _____

8. Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below. **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

10. Are you a U.S. citizen or U.S. national? Yes No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? Yes No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

12. Do you want help paying for medical bills from the last 3 months? Yes No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes No

14. Are you a full-time student? Yes No

15. Were you in foster care at age 18 or older? Yes No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

17. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> Native American Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> or Alaska Native	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
	<input type="checkbox"/> Chinese			<input type="checkbox"/> Other _____



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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

- Employed**
If you're currently employed, tell us about your income. Start with question 18.
- Not employed**
Skip to question 28.
- Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address	19. Employer phone number () -
20. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
21. Average hours worked each WEEK _____	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address	23. Employer phone number () -
24. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
25. Average hours worked each WEEK _____	

26. **In the past year, did you:** Change jobs Stop working Start working fewer hours None of these

27. **If self-employed, answer the following questions:**

- a. Type of work _____
- b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
\$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Unemployment \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions \$ _____ How often? _____ | <input type="checkbox"/> Other income \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security \$ _____ How often? _____ | Type: _____ |
| <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ | |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | |

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

- | | |
|--|---|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Other deductions \$ _____ How often? _____ |
| <input type="checkbox"/> Student loan interest \$ _____ How often? _____ | Type: _____ |

30. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person. ➔

Your total income this year \$ _____	Your total income next year (if you think it will be different) \$ _____
--	--

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix _____ 2. Relationship to you? _____

3. Date of birth (mm/dd/yyyy) _____ 4. Sex Male Female

5. Social Security number (SSN) _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? Yes No
If no, list address: _____

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. **NO. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? Yes No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? Yes No a. **If yes**, how many babies are expected during this pregnancy? _____ Due Date _____

9. Does PERSON 2 need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.  **NO. If no**, SKIP to the income questions on page 5.  Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

12. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type _____

b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? Yes No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? Yes No

13. Does PERSON 2 want help paying for medical bills from the last 3 months?
 Yes No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child?
 Yes No

15. Was PERSON 2 in foster care at age 18 or older?
 Yes No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? Yes No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? Yes No


18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. Race (OPTIONAL—check all that apply.)

White Native American Indian Filipino Vietnamese Guamanian or Chamorro
 Black or African American or Alaska Native Japanese Other Asian Samoan
 Asian Indian Korean Native Hawaiian Other Pacific Islander
 Chinese Other _____

Now, tell us about any income from PERSON 2 

 **NEED HELP WITH YOUR APPLICATION?** Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

STEP 2: PERSON 2

Current Job & Income Information

- Employed**
If you're currently employed, tell us about your income. Start with question 20.
- Not employed**
Skip to question 30.
- Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address _____ 21. Employer phone number
() -

22. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
\$ _____

23. Average hours worked each WEEK _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address _____ 25. Employer phone number
() -

26. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
\$ _____

27. Average hours worked each WEEK _____

28. In the past year, did PERSON 2: Change jobs Stop working Start working fewer hours None of these

29. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

30. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- None
- Unemployment \$ _____ How often? _____
- Pensions \$ _____ How often? _____
- Social Security \$ _____ How often? _____
- Retirement accounts \$ _____ How often? _____
- Alimony received \$ _____ How often? _____
- Net farming/fishing \$ _____ How often? _____
- Net rental/royalty \$ _____ How often? _____
- Other income \$ _____ How often? _____
Type: _____

31. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

- Alimony paid \$ _____ How often? _____
- Student loan interest \$ _____ How often? _____
- Other deductions \$ _____ How often? _____
Type: _____

32. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year** \$ _____ PERSON 2's total income **next year** (if you think it will be different) \$ _____

THANKS! This is all we need to know about PERSON 2.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

STEP 3 Native American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family Native American Indian or Alaska Native?

- If **No**, skip to Step 4.
 Yes. If yes, go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

- YES. If yes**, check the type of coverage and write the person(s) name(s) next to the coverage they have. **NO.**
- | | |
|--|---|
| <input type="checkbox"/> Medicaid _____ | <input type="checkbox"/> Employer insurance _____ |
| <input type="checkbox"/> NJ FamilyCare _____ | Name of health insurance: _____ |
| <input type="checkbox"/> Medicare _____ | Policy number: _____ |
| <input type="checkbox"/> TRICARE (Don't check if you have direct care or Line of Duty) _____ | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> VA health care programs _____ | <input type="checkbox"/> Other |
| <input type="checkbox"/> Peace Corps _____ | Name of health insurance: _____ |
| | Policy number: _____ |
| | Is this a limited-benefit plan (like a school accident policy)? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

- YES. If yes**, you'll need to have your employer complete Appendix A and return to address provided.
 NO. If no, continue to Step 5.

STEP 5 Select your Health Plan

Choose a Health Plan from the list below. If you do not choose now, you will have an opportunity to select a Health Plan before enrollment occurs. You must be enrolled in a Health Plan to receive all of the services offered through NJ FamilyCare. The Health Plan selected only applies if you are eligible for NJ FamilyCare. If you need assistance selecting your Health Plan, contact a Health Benefits Coordinator at 1-800-701-0710, TTY 1-800-701-0720.

- Aetna Better Health® of New Jersey** (Available in Bergen, Camden, Essex, Hudson, Middlesex, Passaic, Somerset & Union counties)
- Amerigroup New Jersey, Inc.** (Available in ALL counties; except Salem County)
- Horizon NJ Health** (Available in ALL Counties)
- UnitedHealthcare Community Plan** (Available in ALL Counties)
- WellCare Health Plans of New Jersey:** (Available in Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex & Union counties ONLY)

I understand that if I'm found eligible and because I have joined a Health Plan, I must follow the rules for obtaining health care from the Health Plan. I understand that I must let my Health Plan and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my Health Plan. I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist. I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the Health Plan as soon as possible after I, or the family member, go to the hospital. I understand that I must keep any medical appointment I have scheduled with a doctor and, if I cannot, I must call the doctor's office to cancel the appointment. I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the Health Plan, I may have to pay for that doctor's services because NJ FamilyCare will not pay for the unapproved service or visit. I understand that I may change to another Health Plan and that I can call the Health Benefits Coordinator to help me do that. I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the Health Plan and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the Health Plan.

? **NEED HELP WITH YOUR APPLICATION?** Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

STEP 6 Read & sign this application.

- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if Federal privacy law requires or allows it, or if State law requires it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support.
- I know that I must promptly tell NJ FamilyCare if anything changes or becomes different from what I wrote on this application including changes in income, address or household size. I can visit njfamilycare.org or call **1-800-701-0710** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare.
- I also authorize any educational institution or school district to release my medical records or those of my child(ren) to the NJ FamilyCare program for the purpose of determining eligibility and billing the Program.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.

(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, NJ Division of Taxation, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow NJ FamilyCare to use income data, including information from tax returns. NJ FamilyCare will send me a notice, let me make any changes, and I can opt out at any time.

If anyone on this application is eligible for NJ FamilyCare

- I am giving to the NJ FamilyCare agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the NJ FamilyCare agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell NJ FamilyCare and I may not have to cooperate.

My right to appeal

If I think NJ FamilyCare has made a mistake, I can appeal its decision. To appeal means to tell someone at NJ FamilyCare that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting NJ FamilyCare at **1-800-701-0710**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Estate Recovery

NJ FamilyCare Medicaid benefits received after the age of 55 may be reimbursable to the State of New Jersey from the member's estate. The recovery may include premium payments made on behalf of the beneficiary. For more information about Estate Recovery, visit http://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature

Date (mm/dd/yyyy)

STEP 7 Mail completed application.

Mail your signed application to:

Bergen County Social Services
Attention Family Care Unit
218 Route 17 North
Rochelle Park, NJ 07662

If you are not registered to vote where you live now, would you like to apply to register to vote? Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this Agency.

For more information on the [Notice of Your Opportunity To Vote Rights](http://www.state.nj.us/state/elections/nvra-forms/nvra-opportunity-form-081810.pdf) visit the link below:
<http://www.state.nj.us/state/elections/nvra-forms/nvra-opportunity-form-081810.pdf>

For more information on the [Voter Registration Application](http://www.state.nj.us/state/elections/voting-information-voter-registration-forms.html) visit the link below:
<http://www.state.nj.us/state/elections/voting-information-voter-registration-forms.html>
(Fill in the required information, *print as a two-sided document*, and fold to mail).

If you would like a Voter Registration Application mailed to you, please check this box .



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APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

You need to include this page when you send in your application.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____ - _____ - _____
--	---

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____	
5. Employer address		6. Employer phone number () - _____	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) () - _____		12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

? **NEED HELP WITH YOUR APPLICATION?** Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

APPENDIX B

Native American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are Native American Indian or Alaska Native. Submit this with your NJ FamilyCare Application for Health Coverage & Help Paying Costs.

Tell us about your Native American Indian or Alaska Native family member(s).

Native American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Certain money received may not be counted for NJ FamilyCare. List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance 	\$ _____ How often? _____	\$ _____ How often? _____

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact NJ FamilyCare. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)



NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

Certification Format for Identity Requirement under the DRA

Case Number:

Certification of Identity

I, _____, hereby certify to the following statements:
(name of parent or guardian)

1. I am the parent or guardian of _____

(names of children as they appear on their birth certificates)

2. _____ was born on _____ in _____.
(Name of child #1) (date of birth) (place of birth)

_____ was born on _____ in _____.
(Name of child #2) (date of birth) (place of birth)

_____ was born on _____ in _____.
(Name of child #3) (date of birth) (place of birth)

_____ was born on _____ in _____.
(Name of child #4) (date of birth) (place of birth)

_____ was born on _____ in _____.
(Name of child #5) (date of birth) (place of birth)

_____ was born on _____ in _____.
(Name of child #6) (date of birth) (place of birth)

3. I am applying for Medicaid/NJ FamilyCare coverage for _____

(child(ren)'s name(s))

4. I have provided accurate information regarding the child(ren) on the Medicaid/NJ FamilyCare application.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willingly false, I am subject to punishment.

Signature of parent or guardian



New Jersey Voter Registration Application

Please print clearly in ink. All information is required unless marked optional.

1 Check boxes that apply: <input type="checkbox"/> New Registration <input type="checkbox"/> Address Change <input type="checkbox"/> Political Party Affiliation or Non-affiliation Change <input type="checkbox"/> Name Change <input type="checkbox"/> Signature Update						FOR OFFICIAL USE ONLY Clerk Registration # Office Time Stamp	
2 Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If No, DO NOT complete this form)</i>		Will you be 18 years of age by the next election? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If No, DO NOT complete this form)</i>					
3 Last Name		First Name	Middle Name or Initial	Suffix (<i>Jr., Sr., III</i>)			
4 Date of Birth							
5 NJ Driver's License Number or MVC Non-driver ID Number			If you DO NOT have a NJ Driver's License or MVC Non-Driver ID, provide the last 4 digits of your Social Security Number. _____			<input type="checkbox"/> by mail <input type="checkbox"/> in person	
<input type="checkbox"/> "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."							
6 Home Address (<i>DO NOT use PO Box</i>)		Apt.	Municipality	County	State		Zip Code
7 Mailing Address if different from above		Apt.	Municipality	County	State		Zip Code
8 Last Address Registered to Vote (<i>DO NOT use PO Box</i>)		Apt.	Municipality	County	State	Zip Code	
9 Former Name if Making Name Change		a. Day Phone Number (<i>Optional</i>) _____ b. E-Mail Address (<i>Optional</i>) _____					
10 Do you wish to declare a political party affiliation? <input type="checkbox"/> Yes, the party name is _____ <i>(Optional)</i> <input type="checkbox"/> No, I do not wish to be affiliated with any political party.							
11 Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Declaration - I swear or affirm that: <input checked="" type="checkbox"/> I am a U.S. Citizen <input checked="" type="checkbox"/> I live at the above address. <input checked="" type="checkbox"/> I will be at least 18 years old on or before the next election		<input checked="" type="checkbox"/> I will have resided in the State and county at least 30 days before the next election <input checked="" type="checkbox"/> I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws		<input checked="" type="checkbox"/> I understand that any false or fraudulent registration may subject me to a fine of up to \$15,000, imprisonment up to 5 years, or both pursuant to R.S. 19:34-1	
Signature: Sign or mark and date on lines below X _____ Date _____				If applicant is unable to complete this form, print the name and address of individual who completed this form. Name _____ Date _____ Address _____			

Important Instructions for sections 5, 6 and 10

5) Registrants who are submitting this form by mail and are registering to vote for the first time: If you do not have any of the information required by section 5, or the information you provide cannot be verified, you will be asked to provide a COPY of a current and valid photo ID, or a document with your name and current address on it to avoid having to provide identification at the polling place.

Note: ID Numbers are Confidential and will not be released by any governmental agency. Any person who uses such numbers illegally shall be subject to criminal penalties.

6) If you are homeless, you may complete section 6 by providing a contact point or the location where you spend most of your time.

10) You may declare a political affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. Completing section 10 is OPTIONAL and will not affect the acceptance of your voter registration application.

Need More Information? Check boxes below if you would like to receive more information about:

- voting by mail
- becoming a poll worker
- polling place accessibility
- voting if you have a disability, including visual impairment
- available election materials in this alternative language:

For further information visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)



New Jersey Voter Registration Information

You can register to vote if:

- You are a United States citizen
- You will be 18 years of age by the next election
- You will be a resident of the State and county 30 days before the election
- You are **NOT** currently serving a sentence, probation or parole because of a felony conviction

Registration Deadline: 21 days before an election

Your County Commissioner of Registration will notify you if your application is accepted.
If it is not accepted, you will be notified on how to complete and/or correct the application.

Questions? visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)

FOLD



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 206 TRENTON NJ

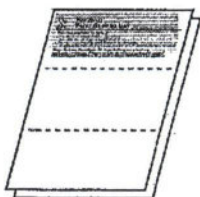
POSTAGE WILL BE PAID BY ADDRESSEE

DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

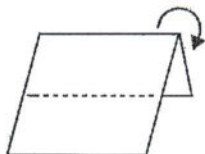


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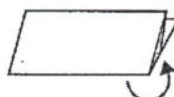
Important: Print out at 100% - DO NOT REDUCE. Fold as illustrated to ensure proper mailing.



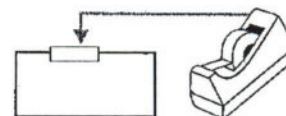
Put both pages
together as shown



1 fold top down



2 fold bottom up



3 Tape top shut

TAPE HERE



State of New Jersey
 Department of State
 Division of Elections

Voter Registration Opportunity

The National Voter Registration Act of 1993 requires the State to provide you with the opportunity to register to vote as an additional service offered by this office. Please complete the form below to advise the agent of your interest to register or not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you decline to register to vote at this time, your decision will remain confidential and will be used only for voter registration purposes. If you do register to vote, the way in which you do so will remain confidential and will be used only for voter registration purposes.

You can register to vote if:

- You are a United States citizen
- You will be 18 years of age by the next election
- You will be a resident of the State and county 30 days before the election
- You are NOT currently serving a sentence, probation or parole because of a felony conviction

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: the NJ Division of Elections, (mailing address) P.O. Box 304, Trenton, NJ 08625-0304; (office location) 225 West State Street, 5th Floor, Trenton, NJ 08608; telephone 609-292-3760, fax number 609-777-1280, TTY 1-800-292-0034, Elections.NJ.gov.

If you would like help in filling out the voter registration application form, we will help you. You can call NJ FamilyCare at 1-800-356-1561. The decision whether to seek or accept help is yours. You may fill out the application form in private.

This section can be returned to NJ FamilyCare at: NVRA Liaison, PO 712, Trenton, NJ 08625-0712

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

- Yes No I am already registered

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE
 DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

 Print Name

 Signature

 Date

For Official Use RTS <input type="checkbox"/> _____ Initial
--