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

ABD Medicaid

Required Verifications

In order to apply for Medicaid as an Aged, Blind or Disabled individual you must complete the attached Customer Information Fact Sheet and the Application (NJFC-ABD-AP-0718). 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).

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

Proof of Identification- Driver's License, Social Security Card or Medicare Card.

Proof of Other Health Insurance- Any other health insurance ID cards you have.

Proof of Residence- Mortgage Bills, Property Tax Bill, Rent Receipts, Fully Executed Lease, PSE&G bill, recent mail addressed to you. If you live in a home with another person, you must also provide a letter signed by that person indicting the living arrangements including how much you pay in rent, utilities and other household expenses.

Proof of Marital Status- Marriage Certificate, Divorce Decree, Death Certificate

Proof of Income- Last eight (8) week's paystubs (if employed), Proof of: Social Security income, Disability income, pension income, alimony, etc. (to request a letter from Social Security detailing you income call 1-800-772-1213). Proof of any other type of income- copy of benefit checks or benefit notice.

Proof of Resources- Last three (3) months of bank statements for all checking, savings and financial accounts including stocks, bonds and annuities, etc. **(Please explain and verify all deposits not reported as income)**, and life insurance policies with cash-in value (Call the life insurance company to send you proof of the cash-in amount).

PA1C- If applicable, PA1C provided by the hospital to eligible non-resident alien.

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

ABD Medicaid

Verificaciones Requeridas

Para solicitor Medicaid como persona Anciana, Ciega o Discapacitada debe completer el Formulario de Información del Cliente y la aplicación (NJFC-ABD-AP-0718). Los formularios correctamente completados deben ser devueltos a la Junta de Servicios Sociales del Condado Bergen, junto con todas las siguientes verificaciones que sean aplicables a su caso:

POR FAVOR ENVÍON COPIAS SOLAMENTE (NO ORIGINALES).

Prueba de Estatus Legal- Certificado de Nacimiento, Pasaporte de Estados Unidos, Certificado de Naturalización, I-94, Visa de entrada a Estados Unidos o Carnet de Residencia (copia de ambos lados).

Prueba de Identidad- Licencia de Conducir, Tarjeta de Medicare, or Tarjeta de Seguro Social.

Prueba de Otro Seguro de Salud- Cualquier otra tarjeta de identificación de seguro de salud que tenga.

Prueba de Residencia- Cuentas Hipotecarias, Impuesto a la Propiedad, Recibos de Alquiler, Contrato de Arrendamiento, Estado de Cuenta de PSE&G, correo reciente dirigida a usted. Si usted vive en un hogar con otra persona, también debe proporcionar una carta firmada por esa persona indicando los arreglos de vivienda, incluyendo la contidad que paga de alquiler, servicios públicos y otros gastos.

Prueba de Estado Civil- Certificado de Matrimonio, Decreto de Divorcio, Certificado de Defunción.

Prueba de Ingresos- Recibos de Pago de las Últimas Ocho (8) Semanas (si trabaja), Prueba de Ingreso de: Seguro Social, discapacidad, pensión, pensión alimenticia, etc. (para solicitor una carta de Seguro Social detallando su ingreso llame al 1-800-772-1213). Prueba de cualquier otro tipo de ingreso.

Prueba de Recursos- Tres (3) estados de cuenta más recientes de sus cuentas bancarias de cheques/ahorros y cuentas financieros tales como acciones, bonos, anualidades, etc. (Favor de explicar y verificar todos los depósitos no reportados como ingresos), y las pólizas de seguro de vida con valor en efectivo (llame a la compañía de seguros de vida para que le envíe prueba del valor en efectivo).

Formulario PA1C- Si no tienes estatus legal y le aplica, el Formulario PA1C que le proporcionó el hospital.

Customer Information Sheet

W

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* _____

*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

Address/Dirección_____

City/Ciudad_____ Zip Code/Codigo Postal_____

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

Telephone/Teléfonos

Home/Casa_____ Cellular _____ Language Spoken/¿Qué idioma(s) habla?_____

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 Nacimento	Social Security Number Numero de Seguro Social	Realtionship Parentezco	Citizenship/Alien Status Estatus Legal	Include in application? Incluir en aplicación?
						☐-Yes/Si ☐-No
						☐-Yes/Si ☐-No
						☐-Yes/Si ☐-No
						☐-Yes/Si ☐-No
						☐-Yes/Si ☐-No
						☐-Yes/Si ☐-No

PLEASE COMPLETE REVERSE SIDE • POR FAVOR COMPLETE PAGÍNA 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.

Customer Information Sheet

Last Name/Apellido_____ First Name/Nombre_____ MI/Inicial_____

Income - For each household member included in this application please provide the information requested below regarding their **monthly** income. Income includes: wages, salary, Social Security, Disability, pension, retirement, alimony, unemployment, child support, veterans benefits and any other money your family receives.

Ingresos - Para cada miembro de su familia incluido en esta solicitud, por favor proporcione la información solicitada abajo con respecto a sus **ingresos mensuales**. Los ingresos incluyen: sueldos, salarios, Seguro Social, discapacidad, pensión, retiro, desempleo, manutención de hijos, beneficios de veteranos y cualquier otro dinero que su familia recibe.

	Household Member Miembro de la Familia	Type of Income Tipo de Ingreso	Monthly Amount Cantidad Mensual		Household Member Miembro de la Familia	Type of Income Tipo de Ingreso	Monthly Amount Cantidad Mensual
1				4			
2				5			
3				6			

Resources - For each household member included in this application please provide the information requested below regarding their resources. Resources include: cash, checking accounts, savings accounts, stocks, bonds, annuities, 401K, life insurance policies with cash-in value, etc.

Recursos - Para cada miembro de su familia incluido en esta solicitud, por favor proporcione la información solicitada abajo con respecto a sus recursos. Los recursos incluyen: dinero en efectivo, cuentas de cheques, cuentas de ahorro, acciones, bonos, anualidades, 401K, seguros de vida con valor en efectivo, etc.

	Household Member Miembro de la Familia	Type of Resource Tipo de Recurso	Amount Cantidad		Household Member Miembro de la Familia	Type of Resource Tipo de Recurso	Amount Cantidad
1				3			
2				4			

In the past year have you received Food Stamps, Welfare or Medicaid in any state? ☐-Yes/Si ☐-No
¿En el último año ha recibido Cupones para Alimentos, Welfare, o Medicaid en cualquier estado?

Health Insurance/Seguro de Salud ☐-Yes/Si ☐-No (Includes Medicare, Hospital, Medicaid, Dental, Prescription Drug Insurance/Incluye Medicare, Hospital, Medicaid, Dental, Seguro de Medicamentos) If yes/Si la respuesta es sí:

Company Name/Nombre de la Compañia: _____ Policy Number/Número de Póliza:_____

Is anyone included on this application pregnant?/¿Está embarazada alguna persona incluida en esta aplicación? ☐-Yes/Si ☐-No

If you answered yes, provide name and due date/ Si la respuesta es sí, indique el nombre y la fecha del parto _____

_____ Signature/Firma

_____ Date/Fecha

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ABD FS GA MED TANF

NJ FAMILYCARE
Affordable health coverage. Quality care.

STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

NJ FamilyCare
Aged, Blind, Disabled Programs APPLICATION

SECTION 1 Applicant

Applicant's Name: _____ _____ _____ _____
Last First Middle Maiden Name

Home Address: _____ _____ _____ _____
Street City State Zip Code

Current Mailing Address (if different from above):

_____ _____ _____ _____
Street City State Zip Code

If Applicant has not lived at the Home Address for 5 years, tell us the previous address:
(Attach additional information if needed)

_____ _____ _____ _____
Street City State Zip Code

Applicant's Phone Number: (___) ___-____ Applicant's E-mail Address: _____

Is the Applicant Blind or Disabled? ❑ Yes If yes, as of what date: _____ ❑ No

Is the Applicant in need of Long Term Services and Supports? (see Brochure) ❑ Yes ❑ No

Has the Applicant ever applied for Long Term Services and Supports before?
❑ Yes If yes, which county _____ ❑ No

Has the Applicant applied for Supplemental Security Income (SSI)?
❑ Yes If yes, when ___ ___ - ___ ___ ___ ___ ❑ No
Month Year

SECTION 2 Demographic Information for the Applicant

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ Sex: ❑ Male ❑ Female
Month Day Year

Citizenship Status: ❑ US Citizen ❑ Refugee ❑ Asylee ❑ Not Lawfully Admitted
❑ Legal Alien _____ USCIS/Alien #_____ Immigration Card #_____
Date of Entry

Official Name on Immigration Document/Card (AKA) _____

Place of Birth: City _____ State _____ Country_____

Social Security Number: ___ ___ ___ - ___ ___ -___ ___ ___ ___ Medicare ID Number: _____

Marital Status: ❑ Single ❑ Married, Date _____ ❑ Divorced, Date _____
❑ Widowed, Spouse's Date of Death _____ ❑ Separated, Date _____ ❑ Child (under age 19)

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HMO choice _____

Date Applied _____

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SECTION 3 Spouse's Name

Also include if divorced, separated or widowed.

Spouse's Name: _____ _____ _____ _____
Last First Middle Maiden Name

Spouse's Date of Birth: __ __ - __ __ - __ __ __ __
Month Day Year

Spouse's Social Security Number: ___ ___ ___ - ___ ___ -___ ___ ___ ___

Is this person also applying for the Aged, Blind, Disabled Programs?

❑ No ❑ Yes, please complete the Spouse Information form.

SECTION 4 Assistance with Application

The applicant can choose someone to help them complete their application. We can contact this person for more information. Select Below:

❑ Authorized Representative
- Complete the Designation of Authorized Representative Form (included).

❑ Power of Attorney

❑ Legal Guardian

❑ Attorney

❑ Spouse

❑ Other, please identify relationship _____

Provide the following information for this person:

Name _____

Address _____ _____ _____ _____
Street City State Zip Code

Phone Number: (___) ___ - ____ E-mail Address: _____

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Date Applied _____

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SECTION 5 Health Insurance Information

❑ **Medicare Part A** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount?_____ ❑ No

❑ **Medicare Part B** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount?_____ ❑ No

❑ **Medicare Part C** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount?_____ ❑ No

❑ **Medicare Part D** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount?_____ ❑ No

Does the Applicant have any other health insurance coverage? ❑ Yes ❑ No

If yes, list below the name of the health coverage, policy number, and any premium costs.

Name of Policy	Policy Number	Policy Premium

Does the Applicant have Long Term Care Insurance? ❑ Yes ❑ No

Does the Applicant have a New Jersey Department of Banking and Insurance approved Long Term Care Partnership Policy? ❑ Yes ❑ No

If the Applicant answered yes to either of these questions, please provide a copy of the policy(s).

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Date Applied _____

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SECTION 6 Living Arrangements

Applicant's current living arrangement, check all that apply.

❑ Home: Own ❑ Rent ❑ ❑ Living with Spouse ❑ Nursing Facility

❑ Assisted Living Facility ❑ Residential Care Facility

❑ Renting a room(s) in another person's residence ❑ Living with Relative or Friend

❑ Other: Living Arrangement: _____

List other people living with the Applicant; include name, age and relationship

_____

_____

SECTION 7 Income Information

This section talks about the income that the Applicant receives. Income is any cash or in kind support that can be used for food or shelter.

Income can be wages, tips, and commissions. Income can also be government benefits (such as Social Security Benefit), interest or dividends.

❑ I do not have any income. If not, how do you pay your bills? _____

_____

Current Job & Income Information

Does the Applicant have any income from employment? ❑ Yes ❑ No

❑ **Employed**
If Applicant is currently employed, tell us about Applicant's income. Start with question 1.

❑ **Self-employed**
Skip to question 10.

❑ **Not employed**
Skip to question 11.

CURRENT JOB 1:

1. Employer name and address _____

_____ _____ ____ _____

2. Employer phone number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

3. Work Income (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks
❑ Twice a month ❑ Monthly ❑ Yearly $ _____

4. Average hours worked each WEEK _____

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CURRENT JOB 2:

(If the Applicant has more jobs and needs more space, attach another sheet of paper.)

5. Employer name and address _____

_____

6. Employer phone number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

7. Work Income (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly $ _____

8. Average hours worked each WEEK _____

9. **In the past year, did the Applicant:** ❑ Change jobs ❑ Stop working ❑ Start working fewer hours ❑ None of these

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

    a. Type of work _____

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

11. **OTHER INCOME:**

Check all that apply, and give the amount and how often does the Applicant get it.

- ❑ None
- ❑ Unemployment $_____ How often? _____
- ❑ Pensions $_____ How often? _____
- ❑ Social Security $_____ How often? _____
- ❑ Retirement accounts $_____ How often? _____
- ❑ Alimony received $_____ How often? _____
- ❑ Child Support $_____ How often? _____
- ❑ Work Compensation/ Disability $_____ How often? _____
- ❑ Cash Support $_____ How often? _____ From who?_____
- ❑ Net rental/royalty $_____ How often? _____
- ❑ Annuity $_____ How often? _____
- ❑ Other income $_____ How often? _____

12. **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 page.**

Your total income **this year** **$** _____

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

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SECTION 7a Spouse's Income

Please complete the following section with all information on Spouse's income

Current Job & Income Information

❑ **Employed**
If Spouse is currently employed, tell us about Spouse's income. Start with question 13.

❑ **Self-employed**
Skip to question 22.

❑ **Not employed**
Skip to question 23.

CURRENT JOB 1:

13. Employer name and address _____

_____

14. Employer phone number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

15. Work Income (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly

$ _____

16. Average hours worked each WEEK _____

CURRENT JOB 2:

(If the Spouse has more jobs and needs more space, attach another sheet of paper.)

17. Employer name and address _____

_____

18. Employer phone number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

19. Work Income (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly

$ _____

20. Average hours worked each WEEK _____

21. **In the past year, did the Spouse:** ❑ Change jobs ❑ Stop working ❑ Start working fewer hours ❑ None of these

22. **If Spouse is self-employed, answer the following questions:**

a. Type of work _____

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

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23. **OTHER INCOME:**
Check all that apply, and give the amount and how often does the Spouse get it.

- ❑ None
- ❑ Unemployment $_____ How often? _____
- ❑ Pensions $_____ How often? _____
- ❑ Social Security $_____ How often? _____
- ❑ Retirement accounts $_____ How often? _____
- ❑ Alimony received $_____ How often? _____
- ❑ Child Support $_____ How often? _____
- ❑ Work Compensation/ Disability $_____ How often? _____
- ❑ Cash Support $_____ How often? _____ From who?_____
- ❑ Net rental/royalty $_____ How often? _____
- ❑ Annuity $_____ How often? _____
- ❑ Other income $_____ How often? _____

24. **YEARLY INCOME:**
Complete only if your income changes from month to month.
If you don't expect changes to your Spouse's income, skip to the next page.

Spouse's total income **this year** **$** _____

Spouse's total income **next** year (if you think it will be different) **$** _____

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SECTION 8 Resources for Applicant and Applicant's Spouse

Please detail all resources owned in full or in part by the Applicant, and/or the Applicant's Spouse. ❑ Cash on hand $ _____

ACCOUNTS: This includes but is not limited to, checking, savings, business checking accounts, ABLE Accounts, Certificates of Deposit (CD), Holiday/Vacation club accounts, Credit Union accounts, Burial Accounts/Funeral Trusts owned or closed by the Applicant and/or Applicant's Spouse within 60 months of application date.

Account Type _____
Bank Name and Address _____
Name(s) on Account _____
Account or Certificate # _____ Current Value _____
If Closed, Date Closed & Value _____

Account Type _____
Bank Name and Address _____
Name(s) on Account _____
Account or Certificate # _____ Current Value _____
If Closed, Date Closed & Value _____

Account Type _____
Bank Name and Address _____
Name(s) on Account _____
Account or Certificate # _____ Current Value _____
If Closed, Date Closed & Value _____

Account Type _____
Bank Name and Address _____
Name(s) on Account _____
Account or Certificate # _____ Current Value _____
If Closed, Date Closed & Value _____

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INVESTMENTS: Including but not limited to: Individual Retirement Accounts (IRAs), Keogh Accounts (401K), Retirement Plans (403B), Land/Mineral Rights, Business Equipment and Inventory, Promissory Notes and Contracts, Stocks, Bonds owned or traded/closed by the Applicant and/or Applicant's Spouse within 60 months of application date.

No Investments ❑

Type of Investment _____
Company _____
Account # _____ Current Value _____
If Closed, Date Closed & Value _____

Type of Investment _____
Company _____
Account # _____ Current Value _____
If Closed, Date Closed & Value _____

Type of Investment _____
Company _____
Account # _____ Current Value _____
If Closed, Date Closed & Value _____

PROPERTY: Properties owned solely by the Applicant, with the Applicant's Spouse and/or with others (including but not limited to Other Homes, Land, Buildings, Time Shares, Life Estates or sold within the last 60 months).

No Property ❑

Type of Real Estate _____
Address _____
Liens, Mortgages or Incumbrances _____ Fair Market Value_____
Owners _____ If Sold, Date _____

Type of Real Estate _____
Address _____
Liens, Mortgages or Incumbrances _____ Fair Market Value_____
Owners _____ If Sold, Date _____

Type of Real Estate _____
Address _____
Liens, Mortgages or Incumbrances _____ Fair Market Value_____
Owners _____ If Sold, Date _____

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LIFE INSURANCE POLICIES

List all life insurance policies owned by the Applicant and/or Applicant's Spouse or for which the Applicant(s) are named insured.

No Life Insurance ❑

Owner _____
Insured _____
Insurance Company _____
Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Owner _____
Insured _____
Insurance Company _____
Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Owner _____
Insured _____
Insurance Company _____
Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Does the Applicant and/or Applicant's Spouse have any knowledge of being named a beneficiary on someone else's policy? ❑ Yes ❑ No

VEHICLES: List all vehicles owned by the Applicant and/or Applicant's Spouse, applying for benefits. List all types of vehicles, including but not limited to, cars, vans, trucks, motor homes, motorcycles, boats, etc.

No Vehicles ❑

Owner _____
Year/Make _____ Model/Style _____
Primary Use _____ Amount Owed _____

Owner _____
Year/Make _____ Model/Style _____
Primary Use _____ Amount Owed _____

Owner _____
Year/Make _____ Model/Style _____
Primary Use _____ Amount Owed _____

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TRUSTS

Testamentory Trust ❑ Special Needs Trust ❑ Qualified Income Trust ❑

Grantor _____

Trustee _____

Beneficiary _____

Trust was funded by ❑ Applicant ❑ Inheritance ❑ Will ❑ Lawsuit ❑ Other

Tax ID# _____ Date trust was initially funded _____

Burial Arrangements

Does the Applicant own any prepaid burial contracts that are irrevocable or revocable?

❑ Yes If yes, please send contract. ❑ No

❑ Burial plots

❑ Account set aside for burial Account #_____ Value _____

Identified Funeral Home (name and address) _____

Has the Applicant or anyone else set up a burial arrangement or contract through a life insurance policy? ❑ Yes If yes, please send policy. ❑ No

OTHER RESOURCES NOT LISTED _____

Has the Applicant established a Plan of Liquidation for any of the resources in Section 8? ❑ Yes ❑ No

SECTION 9 Transfers

Did the Applicant and/or Applicant's Spouse trade, give away, or sell resources in which the Applicant and/or Applicant's Spouse had an interest within the last 60 months, including but not limited to cash, real estate, vehicles, businesses, stocks, bank accounts?

❑ Yes If yes, complete the information below for each transfer. ❑ No

Item Transferred_____Transfer Date_____

Market Value _____ Amount Received _____

Item Transferred_____Transfer Date_____

Market Value _____ Amount Received _____

Item Transferred_____Transfer Date_____

Market Value _____ Amount Received _____

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

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SECTION 10 Legal Issues

Are there any pending claims such as lawsuits, divorce settlements, inheritance, accident claims, Medical Malpractice or other claims? ❑ Yes ❑ No

If Yes, provide details of the claims including but not limited to date monies were received and type of claim.

_____

_____

_____

_____

_____

Attorney's Name _____

Attorney's Phone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Attorney's Address _____

Will the Applicant and/or Applicant's Spouse file a lawsuit in the future? ❑ Yes ❑ No

Does anyone owe the Applicant and/or the Applicant's Spouse money, for example loans, promissory notes and/or mortgages? ❑ Yes ❑ No

If yes, provide details regarding these arrangements. _____

_____

_____

_____

Has the Applicant received medical services within the past 3 months?

❑ Yes ❑ No

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-AP-0718

SECTION 11 Select the Applicant's Health Plan

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

Choose One:

- ❑ **Aetna Better Health® of New Jersey** (Available in ALL counties)
- ❑ **Amerigroup New Jersey, Inc.** (Available in ALL counties)
- ❑ **Horizon NJ Health** (Available in ALL counties)
- ❑ **UnitedHealthcare Community Plan** (Available in ALL counties)
- ❑ **WellCare Health Plans of New Jersey** (Available in ALL counties, except Hunterdon county)

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.

In certain counties, eligible participants age 55 and over who reside in the community needing Long Term Services and Supports may instead have their care provided through PACE (Program of All-Inclusive Care for the Elderly). Call 1-800-792-8820 for more information about PACE in your community.

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-AP-0718

SECTION 12 Rights and Responsibilities

Before signing this document, please read the rights and responsibilities outlined below. If there is anything you do not understand or have questions about, please ask for clarification.

- The information I gave on this form is true to the best of my knowledge. I realize that if I knowingly give false information OR if I knowingly withhold information and I get health benefits for which I am not eligible, I can be criminally punished for fraud and I may have to pay Medicaid for any medical bills which are paid incorrectly.
- If I am a third party applying on behalf of another person, as evidenced by a completed Designation of Authorized Representative form, my signature below indicates that this application has been examined by or read to the applicant and, to the best of my knowledge, the facts are true and complete. I understand as a third party I may be criminally punished for knowingly providing false information.
- I understand that any information I give is subject to verification by the NJ Department of Human Services (DHS). I understand that my medical benefits may be reduced, denied, or stopped because of information received.
- I hereby give permission to DHS to contact any individual or other source who may have knowledge about my circumstances or the circumstances of a person necessary for this application (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, financial institutions and/or credit reporting services), for the sole purpose of verifying the statements I have made.

Estate Recovery

- I understand that Medicaid payments for services received on or after age 55 may be reimbursable to the State of New Jersey from the estate of an individual who received Medicaid benefits. I also understand that this reimbursement may include, but not be limited to, capitation payments made to a managed care organization (MCO) or transportation broker for health coverage, regardless of whether the beneficiary receives services from an individual provider or entity that is reimbursed by the MCO or transportation broker. 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**
- I agree to tell the Eligibility Determining Agency immediately of the following changes:
  1) If anyone receiving health benefits moves out of state;
  2) Changes in where we live or get our mail;
  3) Changes in other health insurance coverage;
  4) Changes in income and/or resources;
  5) Improvement in medical condition, if disabled;
  6) Marriages and/or divorces;

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-AP-0718

7) Family members moving in or out of my household;
8) Sale of my home or other property;
9) Student status.

I understand that failure to do so may result in incorrectly paid benefits and I may have to reimburse the State of New Jersey for those benefits.

- I understand that the outcome of this application may be shared with any provider providing services or who provided services to the applicant/beneficiary.
- I understand, as a condition of eligibility for medical assistance, that I have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.
- I understand that I may request a fair hearing if I am not satisfied with any action taken regarding my application.
- I may be eligible for retroactive NJ FamilyCare coverage for unpaid covered medical services by Medicaid Fee For Service providers during the three (3) months prior to this application. I further understand that these retroactive benefits will only apply to the month(s) that eligibility requirements are met.
- I understand that an individual is only permitted to retain $2,000 or $4,000 in applicable program resources in order to be eligible. I understand that if I am seeking Long Term Services and Supports, NJ FamilyCare will examine transfers of resources that occurred within the look back period before, and anytime after, my first date of applying for benefits.
- I give third parties permission to share information about me with authorized State and County staff conducting investigations pertaining to fraud, fraud prevention and misrepresentation. Third parties include, but are not limited to, financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other governmental agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six (6) months after my benefits stop.
- I understand that by accepting NJ FamilyCare, I give the NJ Department of Human Services the right to any medical support or payments from third parties who would be legally responsible for any medical services paid by NJ FamilyCare for me or any member of my household. I agree to release any medical information needed by the NJ FamilyCare Program or others for the purpose of paying or receiving payment of medical bills. I understand that this is required to get coverage. I agree to help in obtaining medical support and payments from anyone who is legally responsible.

SIGN ON BACK

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-AP-0718

NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7.

The SSNs provided (including for a husband or wife, family members, or dependents) will be used to associate records pertaining to applicants and other persons necessary for the determination of eligibility, to verify identity, to verify income, to check other financial records such as bank account information, to the extent it is useful in verifying eligibility or the amount of medical assistance payments under 42 CFR 435.940 through 435.960, and preventing duplicate participation or incorrectly paid benefits for you and for persons in your household. The SSNs will be used in computer matching and program reviews or audits. These procedures are designed to determine eligibility and to identify persons who fraudulently or wrongfully participate in Medicaid and DMAHS programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak **any other language**, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

SECTION 13 Signature

I, by signing below, attest that I have read and agree to these statements, and that they are truthful and accurate. I fully realize that the Eligibility Determining Agency and NJ Department of Human Services rely upon the truth and accuracy of my statements.

Applicant's Signature _____ Date (mm/dd/yyyy) _____

Authorized Representative Name _____ Relationship _____

Authorized Representative Signature _____ Date (mm/dd/yyyy) _____

This application cannot be considered until it is received by the Eligibility Determining Agency.

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-AP-0718

PRINT, SIGN and SEND to your LOCAL COUNTY WELFARE AGENCY at the appropriate address listed below.

NEW JERSEY COUNTY WELFARE AGENCIES

ATLANTIC COUNTY DIVISION OF INTERGENERATIONAL SERVICES - ABD MEDICAID 101 SOUTH SHORE RD NORTHFIELD, NJ 08225 609-645-7700	**MIDDLESEX** COUNTY BOARD OF SOCIAL SERVICES 181 HOW LANE, P.O. BOX 509 NEW BRUNSWICK, NJ 08903 732-745-3500
BERGEN COUNTY BOARD OF SOCIAL SERVICES 218 ROUTE 17 NORTH ROCHELLE PARK, NJ 07662-3300 201-368-4200	**MONMOUTH** COUNTY DIVISION OF SOCIAL SERVICES 3000 KOZLOSKI RD., P.O. BOX 3000 FREEHOLD, NJ 07728 732-431-6000
BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD. MOUNT HOLLY, NJ 08060-3335 609-261-1000	**MORRIS** COUNTY OFFICE OF TEMPORARY ASSISTANCE 340 W. HANOVER, P.O. BOX 900 MORRISTOWN, NJ 07963-0900 973-326-7800
CAMDEN COUNTY BOARD OF SOCIAL SERVICES ALETHA R. WRIGHT ADMINISTRATION BLDG. 600 MARKET ST. CAMDEN, NJ 08102-1255 856-225-8800	**OCEAN** COUNTY BOARD OF SOCIAL SERVICES 1027 HOOPER AVE., P.O. BOX 547 TOMS RIVER, NJ 08754-0547 732-349-1500
CAPE MAY COUNTY BOARD OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 4005 ROUTE 9 SOUTH RIO GRANDE, NJ 08242-1911 609-886-6200	**PASSAIC** COUNTY BOARD OF SOCIAL SERVICES 80 HAMILTON ST. PATERSON, NJ 07505-2057 973-881-0100
CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 275 NORTH DELSEA DR. VINELAND, NJ 08360-3607 856-691-4600	**SALEM** COUNTY BOARD OF SOCIAL SERVICES 147 S. VIRGINIA AVE. PENNS GROVE, NJ 08069-1797 856-299-7200
ESSEX COUNTY DEPARTMENT OF CITIZEN SERVICES DIVISION OF FAMILY ASSISTANCE & BENEFITS 18 RECTOR ST, 5TH FL. NEWARK, NJ 07102 973-733-3000	**SOMERSET** COUNTY BOARD OF SOCIAL SERVICES 73 E. HIGH ST., P.O. BOX 936 SOMERVILLE, NJ 08876-0936 908-526-8800
GLOUCESTER COUNTY DIVISION OF SOCIAL SERVICES 400 HOLLYDELL DR. SEWELL, NJ 08080 856-582-9200	**SUSSEX** COUNTY DIVISION OF SOCIAL SERVICES 83 SPRING ST., STE. 203. P. O. BOX 218 NEWTON, NJ 07860 973-383-3600
HUDSON COUNTY DEPARTMENT OF FAMILY SERVICES WELFARE DIVISION 257 CORNELISON AVENUE JERSEY CITY, NJ 07302 201-420-3000	**UNION** COUNTY DIVISION OF SOCIAL SERVICES 342 WESTMINSTER AVE. ELIZABETH, NJ 07208-3290 908-965-2700
HUNTERDON COUNTY DEPT OF HUMAN SERVICES DIVISION OF SOCIAL SERVICES 6 GAUNTT PLACE, P.O. BOX 2900 FLEMINGTON, NJ 08822-2900 908-788-1300	**WARREN** COUNTY DIVISION OF TEMPORARY ASSISTANCE AND SOCIAL SERVICES 1 SHOTWELL DRIVE BELVIDERE, NJ 07823 908-475-6301
MERCER COUNTY BOARD OF SOCIAL SERVICES 200 WOOLVERTON ST., P.O. BOX 1450 TRENTON, NJ 08650-2099 609-989-4320	

SUPPLEMENTAL INFORMATION

Designation of Authorized Representative Form

NJ FAMILYCARE
Affordable health coverage. Quality care.

STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

I, _____ hereby authorize the following person or company to be
(Name of Applicant)
my Authorized Representative in my application for Medicaid filed with the Eligibility Determining Agency (EDA) or New Jersey Division of Medical Assistance and Health Services (DMAHS) and in all review of my eligibility. I authorize my representative to take any action which may be necessary to establish my eligibility for NJ FamilyCare.

Name of Representative: _____

Company: _____

Address: _____

City, State, Zip: _____

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

_____ initial — My decision to appoint an Authorized Representative is voluntary and made freely. I understand that signing this document does not relieve me of my responsibility to participate in the NJ FamilyCare eligibility process, including providing information and documents.

_____ initial — I understand that as a result of this authorization, the DMAHS and the applicable EDA may disclose and release information to the Authorized Representative including my Social Security number, financial statements, medical information and the reasons for denial.

_____ initial — I have been fully informed in writing by the Authorized Representative of actual or potential conflicts of interest that may exist between the above named entity and me. I hereby waive any conflict of interest. If there is no conflict of interest, the Authorized Representative has also put that in writing.

_____ initial — I understand that the information shared with the Authorized Representative may affect my liability to a third party, include the Authorized Representative and may be disclosed to others. I hereby hold DMAHS and the EDA harmless for any claim or action resulting from the use or disclosure of information by my Authorized Representative.

SIGN ON BACK

NJFC-AUTH-0718

Signatures

_____ initial — I understand that I may revoke this authorization at any time by notifying the Authorized Representative and the EDA in writing.

_____ initial — I understand that while this authorization is in effect, all notices/correspondence sent by DMAHS and the applicable EDA will only be sent to the Authorized Representative.

_____ initial — I understand that neither the State of New Jersey nor the EDA charge a fee to file a NJ FamilyCare application.

_____ Signature of NJ FamilyCare Applicant or Person Granting Authority

_____ Date (mm/dd/yyyy)

_____ Relationship (Self, Guardian, etc.)

_____ Witness

_____ Date (mm/dd/yyyy)

_____ Print Name

_____ Signature of Authorized Representative

_____ Title (if employee of authorized company)

_____ Print Name

_____ Date (mm/dd/yyyy)

_____ Witness

_____ Date (mm/dd/yyyy)

_____ Print Name

This form has no effect unless witnessed and signed by the person granting authority and by the Authorized Representative or an agent of the company appointed to be the Authorized Representative.

SUPPLEMENTAL INFORMATION

Spouse Information Form

NJ FAMILYCARE
Affordable health coverage. Quality care.

NJ FamilyCare
Aged, Blind, Disabled Programs

STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

SPOUSE INFORMATION

Complete Only if a Spouse is Applying

SECTION 1 Applicant 2 (Spouse)

Applicant 1 Name:

_____ _____ _____ _____
Last First Middle Date of Birth (mm/dd/yyy)

Applicant 2 (Spouse) Name:

_____ _____ _____ _____
Last First Middle Maiden Name

If Applicant has not lived at the Home Address for 5 years, tell us the previous address:
(Attach additional information if needed)

_____ _____ _____ _____
Street City State Zip Code

Current Mailing Address (if different from above).

_____ _____ _____ _____
Street City State Zip Code

Applicant's Phone Number: (_ _ _) _ _ _-_ _ _ _

Applicant's E-mail Address: _____

Is the Applicant Blind or Disabled? ❑ Yes If yes, as of what date: _____ ❑ No

Is the Applicant in need of Long Term Services and Support? (see Brochure) ❑ Yes ❑ No

Has the Applicant ever applied for Long Term Services and Support before?
❑ Yes If yes, which county _____ ❑ No

Has the Applicant applied for Supplemental Security Income (SSI)?
❑ Yes If yes, when ___ ___ - ___ ___ ___ ___ ❑ No
Month Year

SECTION 2 Demographic Information for the Applicant 2 (Spouse)

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ Sex: ❑ Male ❑ Female
Month Day Year

Citizenship Status: ❑ US Citizen ❑ Refugee ❑ Asylee ❑ Not Lawfully Admitted
❑ Legal Alien _____ USCIS/Alien #_____ Immigration Card #_____
Date of Entry

Official Name on Immigration Document/Card (AKA) _____

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-SP-0718

SECTION 2 - DEMOGRAPHIC INFORMATION FOR THE APPLICANT 2 (SPOUSE) - continued

Place of Birth: City _____ State _____ Country _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Medicare ID Number: _____

Marital Status: ❑ Single ❑ Married, Date _____ ❑ Divorced, Date _____
❑ Widowed, Spouse's Date of Death _____ ❑ Separated, Date _____ ❑ Child (under age 19)

SECTION 3 Intentionally left blank

SECTION 4 Assistance with Application

The applicant can choose someone to help them complete their application. We can contact this person for more information. Select Below:

- ❑ Authorized Representative - Complete the Designation of Authorized Representative Form (included).
- ❑ Power of Attorney ❑ Legal Guardian ❑ Attorney ❑ Spouse
- ❑ Other, please identify relationship _____

Provide the following information for this person:

Name _____

Address _____ _____ _____ _____
Street City State Zip Code

Phone Number: (___) ___ - ___ Email Address: _____

SECTION 5 Health Insurance Information - Applicant 2 (Spouse)

❑ **Medicare Part A** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount? _____ ❑ No

❑ **Medicare Part B** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount? _____ ❑ No

❑ **Medicare Part C** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount? _____ ❑ No

❑ **Medicare Part D** Date Eligible _____

Does the Applicant pay a premium? ❑ Yes Monthly Amount? _____ ❑ No

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-SP-0718

SECTION 5 - HEALTH INSURANCE INFORMATION - continued

Does the Applicant have any other health insurance coverage? ❑ Yes ❑ No

If yes, list below the name of the health coverage, policy number, and any premium costs.

Name of Policy	Policy Number	Policy Premium

Does the Applicant have Long Term Care Insurance? ❑ Yes ❑ No

Does the Applicant have a Department of Banking and Insurance approved Long Term Care Partnership Policy? ❑ Yes ❑ No

If the Applicant answered yes to either of these questions, please provide a copy of the policy/policies.

SECTION 6 Living Arrangements - Applicant 2 (Spouse)

Applicant's current living arrangement, check all that apply.

❑ Home: Own ❑ Rent ❑ ❑ Living with Spouse ❑ Nursing Facility

❑ Assisted Living Facility ❑ Residential Care Facility

❑ Renting a room(s) in another person's residence ❑ Living with Relative or Friend

❑ Other: Identify Living Arrangement: _____

List other people living with the Applicant; include name, age and relationship

_____

_____

_____

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-SP-0718

Has the Applicant 2 (Spouse) received medical services within the past 3 months?

❑ Yes ❑ No

SECTION 7 Rights and Responsibilities

Before signing this document, please read the rights and responsibilities outlined below. If there is anything you do not understand or have questions about, please ask for clarification.

- The information I gave on this form is true to the best of my knowledge. I realize that if I knowingly give false information OR if I knowingly withhold information and I get health benefits for which I am not eligible, I can be criminally punished for fraud and I may have to pay Medicaid for any medical bills which are paid incorrectly.
- If I am a third party applying on behalf of another person, as evidenced by a completed Designation of Authorized Representative form, my signature below indicates that this application has been examined by or read to the applicant and, to the best of my knowledge, the facts are true and complete. I understand as a third party I may be criminally punished for knowingly providing false information.
- I understand that any information I give is subject to verification by the NJ Department of Human Services (DHS). I understand that my medical benefits may be reduced, denied, or stopped because of information received.
- I hereby give permission to DHS to contact any individual or other source who may have knowledge about my circumstances or the circumstances of a person necessary for this application (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, financial institutions and/or credit reporting services), for the sole purpose of verifying the statements I have made.

Estate Recovery

- I understand that Medicaid payments for services received on or after age 55 may be reimbursable to the State of New Jersey from the estate of an individual who received Medicaid benefits. I also understand that this reimbursement may include, but not be limited to, capitation payments made to a managed care organization (MCO) or transportation broker for health coverage, regardless of whether the beneficiary receives services from an individual provider or entity that is reimbursed by the MCO or transportation broker. 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**

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-SP-0718

SECTION 7 - RIGHTS AND RESPONSIBILITIES - continued

- I agree to tell the Eligibility Determining Agency immediately of the following changes:
  1) If anyone receiving health benefits moves out of state;
  2) Changes in where we live or get our mail;
  3) Changes in other health insurance coverage;
  4) Changes in income and/or resources;
  5) Improvement in medical condition, if disabled;
  6) Marriages and/or divorces;
  7) Family members moving in or out of my household;
  8) Sale of my home or other property;
  9) Student status.

  I understand that failure to do so may result in incorrectly paid benefits and I may have to reimburse the State of New Jersey for those benefits.
- I understand that the outcome of this application may be shared with any provider providing services or who provided services to the applicant/beneficiary.
- I understand, as a condition of eligibility for medical assistance, that I have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.
- I understand that I may request a fair hearing if I am not satisfied with any action taken regarding my application.
- I may be eligible for retroactive NJ FamilyCare coverage for unpaid covered medical services by Medicaid Fee For Service providers during the three (3) months prior to this application. I further understand that these retroactive benefits will only apply to the month(s) that eligibility requirements are met.
- I understand that an individual is only permitted to retain $2,000 or $4,000 in applicable program resources in order to be eligible. I understand that if I am seeking Long Term Services and Supports, NJ FamilyCare will examine transfers of resources that occurred within the look back period before, and anytime after, my first date of applying for benefits.
- I give third parties permission to share information about me with authorized State and County staff conducting investigations pertaining to fraud, fraud prevention and misrepresentation. Third parties include, but are not limited to, financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other governmental agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six (6) months after my benefits stop.

SIGN ON BACK

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-SP-0718

SECTION 7 - RIGHTS AND RESPONSIBILITIES - continued

- I understand that by accepting NJ FamilyCare, I give the NJ Department of Human Services the right to any medical support or payments from third parties who would be legally responsible for any medical services paid by NJ FamilyCare for me or any member of my household. I agree to release any medical information needed by the NJ FamilyCare Program or others for the purpose of paying or receiving payment of medical bills. I understand that this is required to get coverage. I agree to help in obtaining medical support and payments from anyone who is legally responsible.

NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7.

The SSNs provided (including for a husband or wife, family members, or dependents) will be used to associate records pertaining to applicants and other persons necessary for the determination of eligibility, to verify identity, to verify income, to check other financial records such as bank account information, to the extent it is useful in verifying eligibility or the amount of medical assistance payments under 42 CFR 435.940 through 435.960, and preventing duplicate participation or incorrectly paid benefits for you and for persons in your household. The SSNs will be used in computer matching and program reviews or audits. These procedures are designed to determine eligibility and to identify persons who fraudulently or wrongfully participate in Medicaid and DMAHS programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak **any other language**, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

SECTION 8 Signature - Applicant 2 (Spouse)

I, by signing below, attest that I have read and agree to these statements, and that they are truthful and accurate. I fully realize that the Eligibility Determining Agency and NJ Department of Human Services rely upon the truth and accuracy of my statements.

Applicant 2 (Spouse's) Signature _____ Date (mm/dd/yyyy) _____

Authorized Representative Name _____ Relationship _____

Authorized Representative Signature _____ Date (mm/dd/yyyy) _____

This application can not be considered until it is received by the Eligibility Determining Agency.

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

NJFC-ABD-SP-0718

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 ☐

_____Initial

New Jersey
Voter Registration Application

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

1 Check boxes that apply: ☐ New Registration ☐ Address Change ☐ Political Party Affiliation ☐ Name Change ☐ Signature Update or Non-affiliation Change

FOR OFFICIAL USE ONLY

2 Are you a U.S. Citizen? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

Are you at least 17 years of age? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

Clerk

3 Last Name | First Name | Middle Name or Initial | Suffix *(Jr., Sr., III)*

Registration #

4 Date of Birth

Office Time Stamp

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. _ _ _ _

☐ "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."

		Apt.	Municipality	County	State	Zip Code
6	Home Address *(DO NOT use PO Box)*					
7	Mailing Address if different from above					
8	Last Address Registered to Vote *(DO NOT use PO Box)*					

☐ by mail
☐ in person

9 Former Name if Making Name Change

a. Day Phone Number *(Optional)* _____

b. E-Mail Address *(Optional)* _____

10 Do you wish to declare a political party affiliation? *(Optional)* ☐ Yes, the party name is _____. ☐ No, I do not wish to be affiliated with any political party.

11 Gender ☐ Female ☐ Male

Declaration - I swear or affirm that:
- I am a U.S. Citizen
- I live at the above address
- I am at least 17 years old, and understand that I may not vote until reaching the age of 18.
- I will have resided in the State and county at least 30 days before the next election
- I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws
- 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 party affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. If you are a previously affiliated voter who wants to change political party affiliation or become unaffiliated, you must file this form no later than 55 days before the primary election in order to vote in the primary election. 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 are at least 17 years of age.*
- 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.

**You may register to vote if you are at least 17 years old but cannot vote until reaching the age of 18.*

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)

1 FOLD

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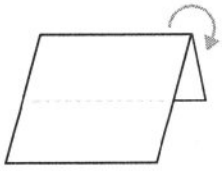
PO BOX 304
TRENTON NJ 08625-9983

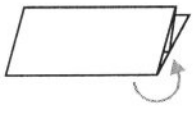
2 FOLD

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

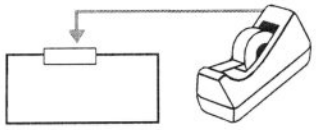
Put both pages together as shown



1 fold top down



2 fold bottom up



3 Tape top shut

3 TAPE HERE

Estado de Nueva Jersey
Secretaría del Estado
Division de Elecciones

Oportunidad de Registro de Votantes

El Acta Nacional de Registro de Votantes de 1993 requiere que el Estado le dé la oportunidad de registrarse para votar como un servicio adicional ofrecido por esta oficina. Por favor complete el formulario siguiente para notificarle al agente si tiene interés o no de registrarse para votar en este momento.

Solicitar el registro o negarse a registrarse para votar no afectará la cantidad de asistencia que le suministre esta agencia.

Si se niega a registrarse para votar en este momento, su decisión será confidencial y se usará sólo para fines del registro de votantes. Si se registra para votar, la forma en que lo haga será confidencial y será usada sólo para fines del registro de votantes.

Usted se puede registrar para votar en los siguientes casos:

- Es ciudadano(a) de Estados Unidos.
- Tendrá los 18 años cumplidos a más tardar en la fecha de las próximas elecciones.
- Será residente del Estado y el condado 30 días antes de las elecciones.
- NO está cumpliendo actualmente ninguna condena, libertad condicional ni libertad bajo fianza debido a una sentencia.

Si usted considera que alguien ha interferido con su derecho a registrarse o no registrarse para votar, su derecho a la privacidad al decidir si debe registrarse o no, o al solicitar el registro de votación, o su derecho a elegir su propio partido político u otra preferencia política, puede presentar una queja en: NJ Division of Elections, (dirección postal) P.O. Box 304, Trenton, NJ 08625-0304; (ubicación de la oficina) 225 West State Street, 5th Floor, Trenton, NJ 08608, Tel: 609-292-3760, Fax: 609-777-1280, TTY: 1-800-292-0034, *Elections.NJ.gov.*

Si desea ayuda para llenar el formulario de solicitud de registro de votantes, con gusto le ayudaremos. Puede llamar a NJ FamilyCare al 1-800-356-1561. La decisión de buscar o aceptar ayuda es suya. Usted puede completar el formulario de solicitud en privado.

Puede enviar esta sección a NJ FamilyCare a: NVRA Liaison, PO 712, Trenton, NJ 08625-0712

Si no está registrado(a) para votar en donde vive actualmente, ¿le gustaría solicitar el registro de votación aquí y ahora?

❑ Si ❑ No ❑ Ya estoy inscrito

SI NO MARCA UNA OPCIÓN, SE CONSIDERARÁ QUE DECIDIÓ NO REGISTRARSE PARA VOTAR EN ESTE MOMENTO.

_____ _____ _____

Nombre en letra de molde Firma Fecha

For Official Use

RTS ☐

_____Initial

Nueva Jersey
Solicitud de Inscripción de Votantes

33

Escriba en imprenta con tinta y letra clara. Toda la información es obligatoria a menos que esté marcada como opcional.

1 Marque las casillas que correspondan: ☐ Inscripción nueva ☐ Cambio de nombre ☐ Cambio de dirección ☐ Actualización de firma o cambio a no afiliación ☐ Afiliación a partido politico

PARA USO OFICIAL EXCLUSIVO

Secretario

2 ¿Es ciudadano estadounidense.? ☐ Sí ☐ No *(Si responde No, NO llene este formulario)*

¿Tiene 17 años de edad como mínimo? ☐ Sí ☐ No *(Si responde No, NO complete este formulario)*

Nro. de inscripción:

3 Apellido	Primer nombre	Segundo nombre o inicial	Sufijo *(Jr., Sr., III)*

4 Fecha de nacimiento (Mes/Dia/Año)

Sello de hora de oficina

5 Número de licencia de conducir de NJ o Número de tarjeta de identificación para no conductores de MVC

Si usted NO tiene licencia de conducir de NJ o tarjeta de identificación para no conductores de MVC, indique los últimos 4 dígitos de su número de Seguro Social ____

__ __ __ __ __ __ __ __ __ __ __ __ __ __

☐ "Juro o declaro que NO tengo licencia de conducir de NJ, tarjeta de identificación para no conductores de MVC ni número de Seguro Social".

	Apto.	Municipalidad	Condado	Estado	Código Postal
6 Domicilio *(NO use Apartado Postal)*					
7 Dirección de envío, si es diferente a la anterior					
8 Última dirección donde está inscrito para votar *(NO use Apartado Postal)*					

☐ por correo
☐ en persona

9 Nombre anterior si efectúa cambio de nombre

a. Número de teléfono durante el día *(opcional)* _____

b. Dirección de correo electrónico *(opcional)* _____

10 ¿Desea declarar la afiliación a un partido político? *(opcional)* ☐ Sí, el nombre del partido es _____.

☐ No, no deseo afiliarme a ningún partido político.

11 Sexo
☐ Femenino
☐ Masculino

Declaración -Juro o declaro que:
- Soy ciudadano de los EE.UU.
- Vivo en el domicilio indicado arriba
- Tengo al menos 17 años de edad y entiendo que no puedo votar hasta que haya cumplido 18 años de edad.
- Habré residido en el Estado y condado al menos 30 días antes de las próximas elecciones
- No estoy en libertad condicional, vigilada o cumpliendo una condena debido a un delito grave conforme a una ley federal o estatal
- Entiendo que toda inscripción falsa o fraudulenta puede someterme a una multa de hasta $15.000, prisión de hasta 5 años o ambas, conforme a R.S. 19:34-1

Firma: Firme o coloque una marca e indique la fecha en la línea a continuación

X _____ Fecha _____

Si el solicitante no puede llenar este formulario, escriba el nombre y dirección de la persona que lo completó.

Nombre _____

Fecha _____

Domicilio _____

_____

Instrucciones importantes para las secciones 5, 6 y 10

5) Solicitantes que envíen este formulario por correo y se inscriban para votar por primera vez: Si no tiene la información que se requiere en la sección 5 o la información que usted suministra no se puede verificar, se le pedirá que proporcione una COPIA de un documento de identidad con fotografía válido y vigente o un documento con su nombre y domicilio actual para evitar tener que presentar el documento de identidad en el centro de votación.

Nota: *Los números de identidad son confidenciales y ningún organismo de gobierno los divulgará. Toda persona que utilice dichos números ilegalmente estará sujeta a sanciones penales.*

6) Si usted está desamparado, puede completar la sección 6 e indicar un punto de contacto o el lugar donde pasa la mayor parte del tiempo.

10) Usted puede declarar una afiliación a un partido político o declarar no estar afiliado a ninguno, independientemente de cualquier afiliación partidaria anterior. Si usted es un votante que anteriormente se había afiliado a un partido y ahora desea cambiar de afiliación partidaria o anular la afiliación, debe presentar este formulario antes de los 55 días previos a las elecciones primarias a fin de votar en dichas elecciones. La sección 10 es OPCIONAL y no afectará la aceptación de su solicitud de inscripción de votante.

¿Necesita más información? Marque las casillas a continuación si desea recibir más información acerca de:

☐ votación por correo
☐ cómo ser auxiliar electoral
☐ acceso al centro de votación
☐ cómo votar si tiene una discapacidad, incluso impedimento visual
☐ material electoral disponible en este otro idioma: _____

Para obtener más información, visite **Elections.NJ.gov** o llame a la línea gratuita **1-877-NJVOTER** (1-877-658-6837)

New Jersey
Información de Inscripción de Votantes

Usted puede inscribirse para votar si:

- Es ciudadano de los Estados Unidos.
- Tiene 17 años de edad como mínimo.*
- Habrá residido en el Estado y condado al menos 30 días antes de las próximas elecciones.
- Actualmente **NO** está en libertad condicional o vigilada ni cumpliendo una condena debido a un delito grave.

**Puede inscribirse para votar si tiene 17 años de edad como mínimo pero no podrá votar hasta cumplir 18 años.*

Plazo de Inscripción: Hasta 21 días antes de las elecciones

Su Comisionado de Inscripciones del Condado le notificará si su solicitud fue aceptada.
Si no fue aceptada, se le avisará cómo completar y/o corregir la solicitud.

¿Tiene alguna pregunta? Visite Elections.NJ.gov o llame a la línea gratuita 1-877-NJVOTER (1-877-658-6837)

1 PLIEGUE

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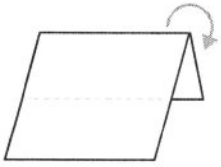
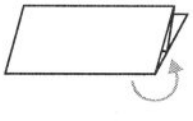
2 PLIEGUE

Importante: Imprima al 100%. NO HAGA REDUCCIONES. Pliegue como se ilustra para asegurar que se envíe correctamente.

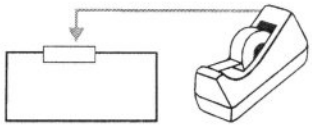
Coloque ambas hojas juntas como se muestra



1 Pliegue la parte superior hacia abajo



2 Pliegue la parte inferior hacia arriba



3 Selle la parte superior con cinta adhesiva

3 SELLE CON CINTA ADHESIVA AQUÍ