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 (PA-1G). 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 indicating 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 your 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 bank statements for all checking/savings, and financial accounts including stocks, bonds, 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 hospital to eligible non-resident alien.

BERGEN COUNTY BOARD OF SOCIAL SERVICES
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# ABD Medicaid

## Verificaciones Requeridas

Para solicitar Medicaid como persona Anciana, Ciega o Discapacitada debe completar el Formulario de Información del Cliente y la aplicación (PA-1G). 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 ENVÍEN <u>COPIAS SOLAMENTE</u> (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 of Identidad** – Licencia de Conducir, Tarjeta de Medicare, o 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 cantidad 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 solicitar 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

**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/Codigo Postal__________________

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

*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

**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<br>Fecha de Nacimento | Social Security Number<br>Numero de Seguro Social | Realtionship<br>Parentezco | Citizenship/Alien Status<br>Estatus Legal | Include in application?<br>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<br>Miembro de la Familia | Type of Income<br>Tipo de Ingreso | Monthly Amount<br>Cantidad Mensual | | Household Member<br>Miembro de la Familia | Type of Income<br>Tipo de Ingreso | Monthly Amount<br>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<br>Miembro de la Familia | Type of Resource<br>Tipo de Recurso | Amount<br>Cantidad | | Household Member<br>Miembro de la Familia | Type of Resource<br>Tipo de Recurso | Amount<br>Cantidad |
|---|---|---|---|---|---|---|---|
| 1 | | | | 3 | | | |
| 2 | | | | 4 | | | |

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

**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**

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 Zip Code

Mailing Address (if different from above): ______________________________

____________________________________________

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

Applicant's E-mail Address: ______________________________

Is the Applicant Blind or Disabled: ❏ Yes If yes, as of what date: ______________ ❏ No

## Legal Representation

Is there an Authorized Representative, Legal Guardian, Power of Attorney, or an attorney representing the Applicant? ❏ Yes ❏ No

If the Applicant answered yes:

1. Provide information about this person.
2. Complete the Designation of Authorized Representative Form (included).

Name ____________________________________________

Address ____________________________________________

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

E-Mail Address ____________________________________________

❏ Authorized Representative ❏ Power of Attorney ❏ Legal Guardian ❏ Attorney

❏ Other, please identify ______________________________

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| --- |
| HMO choice ______________ |
| Date Applied ______________ |
| Registration # ______________ |

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## SECTION 2 Demographic Information for the Applicant

Date of Birth: ____ ____ - ____ ____ - ____ ____ ____ ____
Month Day Year

Citizenship Status: ❑ US Citizen ❑ Refugee ❑ Asylee ❑ Legal Alien ____________________
Date of Entry

❑ If not lawfully admitted, evaluate for Emergency Medical Services for Aliens.

Place of Birth: City __________________________ State _______________ Country________________

Sex: ❑ Male ❑ Female

Social Security Number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Medicare ID Number: ____________________________________________

Marital Status:
- ❑ Single
- ❑ Married, if married, complete section 3
- ❑ Divorced
  Date ___________
- ❑ Widowed
- ❑ Child (under age 19)
- ❑ Separated
  Date ___________

## SECTION 3 Spouse's Name

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.

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## SECTION 4 Health Insurance Information

❑ **Medicare Part A** Date Eligible ______________________

Does the Applicant pay a premium? ❑ Yes How Much?______________________ ❑ No

❑ **Medicare Part B** Date Eligible ______________________

Does the Applicant pay a premium? ❑ Yes How Much?______________________ ❑ No

❑ **Medicare Part C** Date Eligible ______________________

Does the Applicant pay a premium? ❑ Yes How Much?______________________ ❑ No

❑ **Medicare Part D** Date Eligible ______________________

Does the Applicant pay a premium? ❑ Yes How Much?______________________ ❑ 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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## SECTION 5 Living Arrangements

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

❑ Home ❑ 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 6 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. Wages/tips (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. Wages/tips (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 THIS MONTH:**
    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? ____________

    ❑ Inheritance $____________ How often? ____________

    ❑ 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 6A 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. Wages/tips (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 need more space, attach another sheet of paper.)

17. Employer name and address ______________________________________________

______________________________________________

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

19. Wages/tips (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 THIS MONTH:**

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? __________

❑ Prizes/Awards $__________ How often? __________

❑ Net farming/fishing $__________ How often? __________

❑ Inheritance $__________ How often? __________

❑ Net rental/royalty $__________ How often? __________

❑ Annuity $__________ How often? __________

❑ Other income $__________ How often? __________

24. **YEARLY INCOME**:

**Complete only if your Spouse's income changes from month to month.**

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

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

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## SECTION 7 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 $ ______________ ❑ No Resources

**ACCOUNTS:** This includes but is not limited to, checking, savings, business checking 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 Name** ______________________
Bank Address ______________________
Name(s) on Account ______________________
Account or Certificate # ______________________ Current Value ______________
If Closed, Date Closed & Value ______________________

**Account Name** ______________________
Bank Address ______________________
Name(s) on Account ______________________
Account or Certificate # ______________________ Current Value ______________
If Closed, Date Closed & Value ______________________

**Account Name** ______________________
Bank Address ______________________
Name(s) on Account ______________________
Account or Certificate # ______________________ Current Value ______________
If Closed, Date Closed & Value ______________________

**Account Name** ______________________
Bank 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.

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).

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

Owner ______________________________
Insured ______________________________
Insurance Company ______________________________
Policy # ______________ Cash Value ________ Term or Whole Life ________

Owner ______________________________
Insured ______________________________
Insurance Company ______________________________
Policy # ______________ Cash Value ________ Term or Whole Life ________

Owner ______________________________
Insured ______________________________
Insurance Company ______________________________
Policy # ______________ Cash Value ________ Term or Whole Life ________

Does the Applicant 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.

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

Grantor ______________________________

Trustee ______________________________

Beneficiary ______________________________

Trust was funded by ❑ Applicant ❑ Inheritance ❑ Will ❑ 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 7?** ❑ Yes ❑ No

## SECTION 8 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 account?

❑ 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 # ____________________

# SECTION 9 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 ______________________________

______________________________________________

______________________________________________

______________________________________________

**Does the Applicant have any unpaid bills for medical services within the past 3 months?**
❑ Yes ❑ No

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## SECTION 10 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 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.

**FOR OFFICE USE ONLY**

Date Applied ______________________________

Registration # ______________________________

NJFC-ABD-AP-0416

## SECTION 11 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 (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I have made.
- **I understand that NJFamilyCare benefits received on or after age 55 may be reimbursable to the State of New Jersey from my estate. 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, regardless of whether I receive services from an individual or entity that is reimbursed by the MCO or transportation broker.**
- 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.

**FOR OFFICE USE ONLY**

Date Applied ______________________________

Registration # ______________________________

NJFC-ABD-AP-0416

- 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 I will not be discriminated against because of race, color, religion, sex, disability, national origin, or marital, parental, or birth status. To file a complaint of discrimination, I should contact the U.S. Department of Health and Human Services (HHS) in writing to the HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD). HHS is an equal opportunity provider and employer.
- 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.

**FOR OFFICE USE ONLY**

Date Applied ____________________

Registration # ____________________

NJFC-ABD-AP-0416

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

**Your SSN will be used to check your identity, prevent duplicate participation, and facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits and to make sure you are eligible for Medicaid. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid 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.**

## SECTION 12 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 ____________

Authorized Representative Name ____________________ Relationship ____________

Authorized Representative Signature ____________________ Date ____________

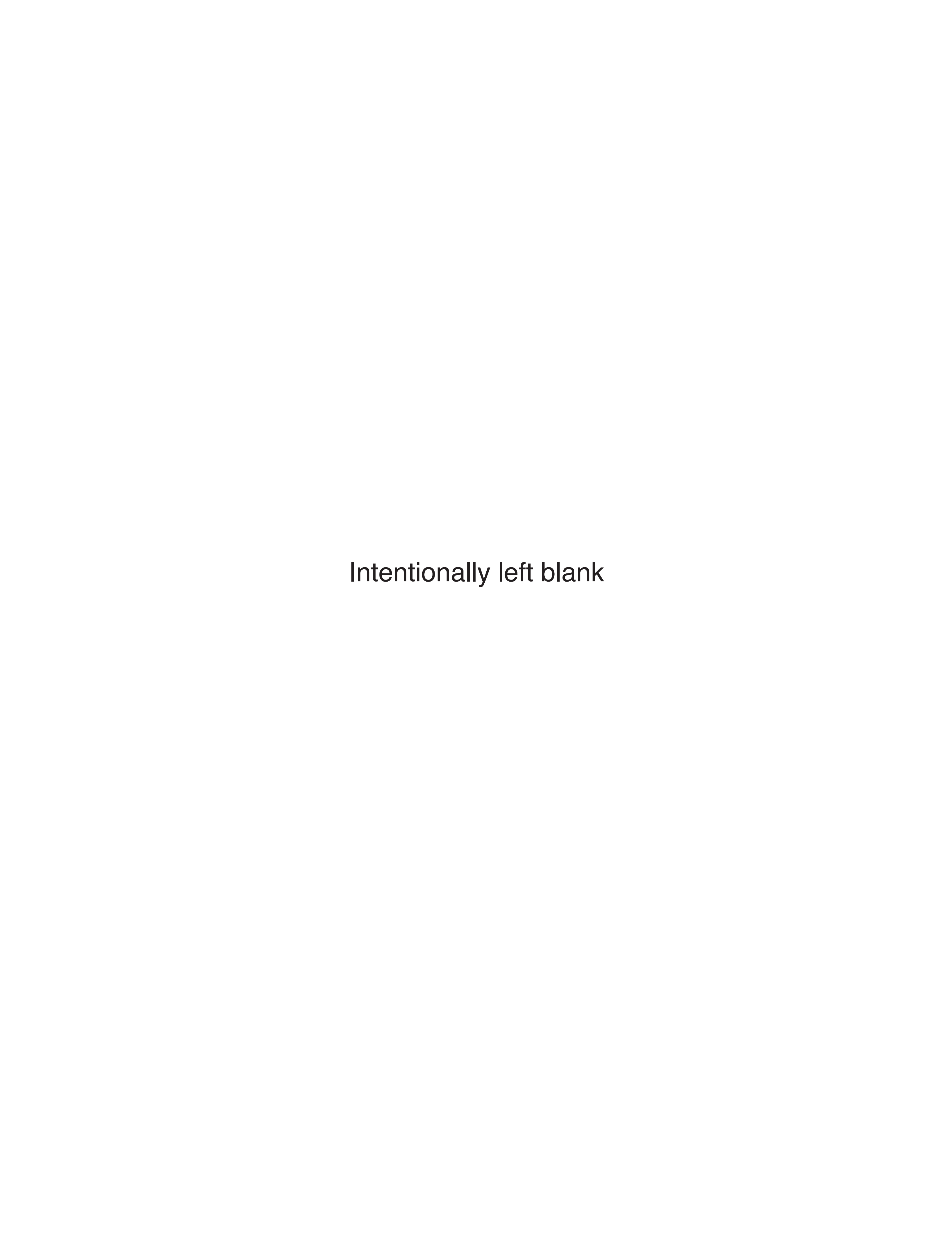
**FOR OFFICE USE ONLY**

Date Applied ____________________

Registration # ____________________

# SUPPLEMENTAL INFORMATION

## Designation of Authorized Representative Form



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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 interests 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 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-0416

## 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 ____________

Relationship (Self, Guardian, etc.) ____________________

Witness ____________________ Date ____________

Print Name ____________________

Signature of Authorized Representative ____________________ Title (if employee of authorized company) ____________

Print Name ____________________ Date ____________

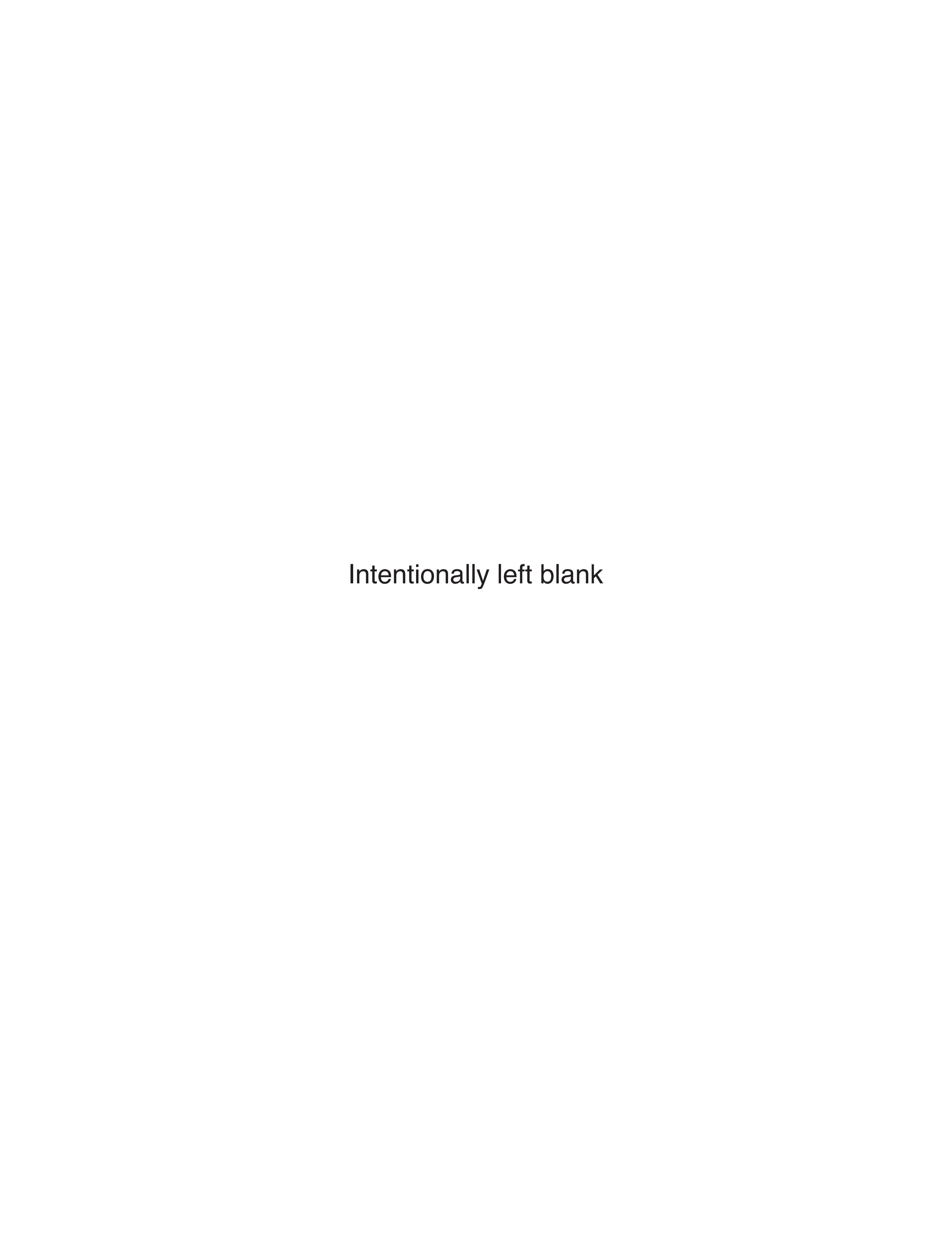
Witness ____________________ Date ____________

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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# 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

Applicant 2 (Spouse) Name:

______________________________________________

Last First Middle Maiden Name

Home Address: ______________________________________________

Street City Zip Code

Mailing Address (if different from above): ______________________________

______________________________________________

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

Applicant's E-mail Address: ______________________________________________

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

## Legal Representation - Applicant 2 (Spouse)

Is there an Authorized Representative, Legal Guardian, Power of Attorney, or an attorney representing the Applicant? ❑ Yes ❑ No

If the Applicant answered yes:

1. Provide information about this person.
2. Complete the Designation of Authorized Representative Form (included).

Name ______________________________________________

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

E-Mail Address ______________________________________________

❑ Authorized Representative ❑ Power of Attorney ❑ Legal Guardian ❑ Attorney

❑ Other, please identify ______________________________________________

**FOR OFFICE USE ONLY**

Date Applied ____________________

Registration # ____________________

NJFC-ABD-SP-0416

## SECTION 2 Demographic Information for the Applicant 2 (Spouse)

Date of Birth: ____ ____ - ____ ____ - ____ ____ ____ ____
Month Day Year

Citizenship Status: ❑ US Citizen ❑ Refugee ❑ Asylee ❑ Legal Alien ____________________
Date of Entry

❑ If not lawfully admitted, evaluate for Emergency Medical Services for Aliens.

Sex: ❑ Male ❑ Female

Social Security Number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Medicare ID Number: ________________________________________

## SECTION 3 Intentionally left blank

## SECTION 4 Health Insurance Information - Applicant 2 (Spouse)

❑ **Medicare Part A** Date Eligible ________________________________

Does the Applicant pay a premium? ❑ Yes How Much?________________________ ❑ No

❑ **Medicare Part B** Date Eligible ________________________________

Does the Applicant pay a premium? ❑ Yes How Much?________________________ ❑ No

❑ **Medicare Part C** Date Eligible ________________________________

Does the Applicant pay a premium? ❑ Yes How Much?________________________ ❑ No

❑ **Medicare Part D** Date Eligible ________________________________

Does the Applicant pay a premium? ❑ Yes How Much?________________________ ❑ No

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Date Applied ____________________

Registration # ____________________

NJFC-ABD-SP-0416

## SECTION 4 - 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 5 Living Arrangements - Applicant 2 (Spouse)

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

❑ Home ❑ 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 # ____________________

**Does Applicant have any unpaid bills for medical services within the past 3 months?**

❑ Yes ❑ No

## SECTION 6 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.**

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- I hereby give permission to DHS to contact any individual or other source who may have knowledge about my circumstances (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I have made.
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**FOR OFFICE USE ONLY**

Date Applied ____________________

Registration # ____________________

## SECTION 6 - 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;
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    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, 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.
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- 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.

**FOR OFFICE USE ONLY**

Date Applied ______________________________

Registration # ______________________________

NJFC-ABD-SP-0416

**SECTION 6 - RIGHTS AND RESPONSIBILITIES - continued**

- I understand that I will not be discriminated against because of race, color, religion, sex, disability, national origin, or marital, parental, or birth status. To file a complaint of discrimination, I should contact the U.S. Department of Health and Human Services (HHS) in writing to the HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD). HHS is an equal opportunity provider and employer.
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**NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7.**

**Your SSN will be used to check your identity, prevent duplicate participation, and facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits and to make sure you are eligible for Medicaid. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid 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.**

## SECTION 7 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 __________ |
| Authorized Representative Name ______________________ | Relationship __________ |
| Authorized Representative Signature ______________________ | Date __________ |

**FOR OFFICE USE ONLY**

Date Applied ______________________

Registration # ______________________

NJFC-ABD-SP-0416