# FOOD STAMPS, GA, and/or TANF

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

# FOOD STAMPS, GA, and/or TANF

## Required Verifications

In order to apply for Foods Stamps, General Assistance, or TANF you must complete the attached Customer Information Fact Sheet and the Application (WFNJ-1J). 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 <u>COPIES ONLY</u> (NO ORIGINALS).**

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

**Proof of Identification** – Driver's License, Social Security Card.

**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 four (4) week's paystubs (if employed), Proof of: Social Security income, Disability income, pension income, Child Support, 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. If you are self-employed you must provide a copy of your most recent tax return including all corresponding schedules.

**Proof of Resources** – Most recent bank statement for each personal and business checking/savings account, and financial accounts including stocks, bonds, annuities, etc. (**Please explain and verify all deposits not reported as income**).

# FOOD STAMPS, GA, and/or TANF

# FOOD STAMPS, GA, and/or TANF - ESPAÑOL

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

# Cupones de Alimentación, GA y/o TANF

## 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, o Carnet de Residencia (copia de ambos lados).

**Prueba of Identidad** – Licencia de Conducir, Tarjeta de Seguro Social.

**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 Cuatro (4) Semanas (si trabaja), Prueba de Ingreso de: Seguro Social, discapacidad, pensión, manutención de niños, 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. Si trabajas por cuenta propia debe proveer todas las páginas de su declaración de impuestos más reciente.

**Prueba de Recursos** - Estados de cuenta más recientes de cada cuenta bancaria personal y comercial de cheques / ahorros y cuentas financieros tales como acciones, bonos, anualidades, etc. (Favor de explicar y verificar todos los depósitos no reportados como ingresos.

# FOOD STAMPS, GA, and/or TANF - ESPAÑOL

**APPLICATION AND AFFIDAVIT FOR PUBLIC ASSISTANCE**

**OFFICE USE ONLY**

**IM Worker** _____ **Date** _____ **Case Number** _____

**IM Supervisor** _____ **Date** _____ **Related Case Number(s)** _____

**TANF Status: ( ) NA ( ) RA ( ) RO ( ) TR** **Date Registered** _____

**SECTION I**

APPLICANT: Please use a pen to complete this form carefully and accurately. IF YOU ARE NOT SURE OF ANY ANSWER, LEAVE THE SPACE BLANK. If you have any questions, ask the county welfare worker.

**DO NOT WRITE IN THE SHADED BOXES**

**1.** For Which Program(s) Do You Wish to Apply or Reapply?

**( ) TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)** **( ) GENERAL ASSISTANCE** **( ) NJ SNAP PROGRAM**

**( ) EMERGENCY ASSISTANCE** **( ) KINSHIP CARE SUBSIDY PROGRAM**

I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to continuously and actively seek employment in an effort to gain self-sufficiency.
I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to register for work with New Jersey One Stop Career Center.

**2.** Are you willing to work? **[ ] YES** **[ ] NO**

**3.** Applicant's name: _____
(LAST) (FIRST) (MI) (MAIDEN)

**4.** Resident Address: **The place where you actually live:**

_____
(NUMBER AND STREET OR RFD) (CITY) (STATE) (ZIP CODE)

Address where your mail goes if different from your resident address above.

_____
(P.O. BOX, STREET ADDRESS, OR RFD) (CITY) (STATE) (ZIP CODE)

Your telephone number: **HOME** ( ) _____ **WORK** ( ) _____ **CELL** ( ) _____

**5.** New Jersey Residence (NOT APPLICABLE FOR NJ SNAP PURPOSES)

**RESIDENCE VERIFICATION**

Do you plan to continue living in New Jersey? **[ ] YES** **[ ] NO**
If **"NO",** EXPLAIN: _____.

**6.** You can authorize a person(s) outside your household to apply for NJ SNAP or GA for you, to obtain NJ SNAP benefits or GA benefits, or to use NJ SNAP benefits to purchase food for you. If you are eligible for NJ SNAP benefits, the individual you designate will receive a FAMILIES FIRST EBT card that he or she can use to buy your food. If you wish to designate such a person, complete the following information:

| Name of Authorized Representative | Date of Birth | Address | SSN (Optional) | Telephone Number |
|---|---|---|---|---|
| | | | | |

**QUESTIONS 7 and 8 BELOW - FOR NJ SNAP APPLICANTS ONLY**

**7.** You have the right to file an application for NJ SNAP immediately by providing your name, address, signature and date signed. If you are determined eligible, your benefits will be paid from that date. (If you file an application and provide all the necessary information about your circumstances and are found eligible, you can get NJ SNAP within 30 days of the date the NJ SNAP office receives your application.)

**8.** If you have very little income and resources, you may be eligible for expedited benefits (to be received within 7 days. **YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL DETERMINE IF YOU QUALIFY FOR THIS SERVICE:**

(a) Is your household's total gross monthly income less than $150.00 and your household's total liquid resources (such as cash or checking/savings accounts) $100.00 or less? **[ ] YES** **[ ] NO**

(b) Is your household's monthly rent or mortgage plus utilities more than your household's total monthly gross income plus total liquid resources? **[ ] YES** **[ ] NO**

(c) Is your household a migrant or seasonal farm-working household with little or no income? **[ ] YES** **[ ] NO**

**OFFICE USE ONLY**

**CATEGORICAL ELIGIBILITY:**
**Does everyone in the household receive Public Assistance (WFNJ) or SSI?** **[ ] YES** **[ ] NO**

**9.** _____
(SIGNATURE OF PERSON INITIATING APPLICATION) (DATE SIGNED)

**SECTION II**

**10. BASIC INFORMATION**: (List each person in the household for whom application is being made, including yourself.)
List adult applicants first, beginning with the female adult, then the oldest to the youngest child.
**For NJ SNAP purposes**, people who live, purchase food and eat with you should be counted as household members.

**NOTE: The submission of Social Security numbers (SSNs) for all household members is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036; Public Law 104-193 requires the submission of SSNs for all individuals applying for WFNJ. Your SSN will be used to determine whether your household is eligible or continues to be eligible to participate in the NJ SNAP Program and/or WFNJ program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a NJ SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims action. The providing of the requested information, including the SSN of each household member, is voluntary for NJ SNAP purposes. However, failure to provide this information will result in the denial of NJ SNAP benefits and/or WFNJ benefits to your household.**

| | | |
|---|---|---|
| **OFFICE USE ONLY**<br><br>**FOR TANF ONLY PURPOSES**<br><br>_____<br>Date WFNJ-1L Completed<br><br>_____ | The question below is asked for research purposes in accordance with the Civil Rights Act of 1964. (Failure to answer will not affect eligibility.) **For NJ SNAP purposes only**! If you do not answer, your eligibility worker will complete it for you. You must complete the **RACE** and **ETHNICITY** section.<br><br>**RACE**<br><br>I - American Indian or Alaska Native<br>A - Asian<br>B – Black or African American<br>H – Native Hawaiian or other Pacific Islander<br>W- White<br><br>0 – American Indian or Alaska Native and Asian<br>1 – American Indian or Alaska Native and Black or African American | 2 American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander<br>3 American Indian or Alaska Native and White<br>4 Asian and Black or African American<br>5 Asian and Native Hawaiian or Other Pacific Islander<br>6 Asian and White<br>7 Black or African American and Native Hawaiian or other Pacific Islander<br>8 Black or African American and White<br>9 White and Native Hawaiian or Other Pacific Islander<br>**Ethnicity**<br><br>1 Hispanic or Latino<br>2 Not Hispanic or Latino |

| **Name** | **Social Security Number** | **Birthdate**<br>**Birthplace** | **Relationship To Applicant** | **Sex (F) or (M)** | **Race/ Ethnicity** | **Legal Alien & BCIS Status** | **Marital Status** | **Grade and School** | |
|---|---|---|---|---|---|---|---|---|---|
| **Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i.<br>**For Office Use Only** | | | | | | | | | |
| **Other Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i.<br>**For Office Use Only** | | | | | | | | | |
| **Other Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i.<br>**For Office Use Only** | | | | | | | | | |

| Name | Social Security Number | Birthdate<br>Birthplace | Relationship To Applicant | Sex (F) or (M) | Race/ Ethnicity | Legal Alien & BCIS Status | Marital Status | Grade and School | |
|---|---|---|---|---|---|---|---|---|---|
| **Other Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i<br>**For Office Use Only** | | | | | | | | | |
| **Other Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i<br>**For Office Use Only** | | | | | | | | | |
| **Other Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i.<br>**For Office Use Only** | | | | | | | | | |
| **Other Applicant**<br>Last | | | | | | | | | **PA**<br>**NJ SNAP** |
| First m.i.<br>**For Office Use Only** | | | | | | | | | |

**11.** List Names of Aliens/Non-Citizens in Your Household

| NAME | DATE OF ENTRY/ COUNTRY OF ORIGIN | REGISTRATION # | SPONSOR NAME/ RESETTLEMENT AGENCY | SPONSOR/ RESETTLEMENT AGENCY ADDRESS | DATE APPLIED FOR CITIZENSHIP | SPONSOR INCOME |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**12.** List Other Persons in the Home <u>not Listed Above</u> (Include Roomers/Boarders)

| NAME | RELATIONSHIP TO APPLICANT |
|---|---|
| | |
| | |
| | |

**12a**. List an Emergency Contact Person (GA Cases Only) _____.

Phone #_____ Address_____.

**13.** Expectant Mother's Name_____Expected Date of Birth_____
Doctor's Name_____ Doctor's Address_____

**14.** What is the main language spoken in your home? _____.

| **15.** Do you or any member of the applicant household receive or have you received TANF in New Jersey or any other state, territory, or General Assistance (GA) in New Jersey since April 1997? | | | **[ ] Yes [ ] No** |
|---|---|---|---|
| Individual Receiving Assistance | Type of Assistance | When | Assistance Provider |
| | | | |
| | | | |

| **16.** Are you or any member of your household a fleeing felon or in violation of a condition of parole or probation imposed by a Federal or State court? | **[ ] Yes [ ] No** |
|---|---|
| Individual Fleeing or in Violation | Fleeing From |
| | |
| | |

| **17.** Have you or any member of your household been convicted of fraudulently receiving means tested benefits in two or more places at the same time? | | | **[ ] Yes [ ] No** |
|---|---|---|---|
| Individual Convicted of Fraud | Where Fraud Occurred | When | What Benefits |
| | | | |
| | | | |

| **18.** Since August 22, 1996, have you or any member of your applicant household committed and been convicted of possession, use or distribution of a controlled substance, which is an indictable offense**? Applies to GA only** | | **[ ] Yes [ ] No** |
|---|---|---|
| Individual Committing Offense | Type of Offense | Where Did Offense Occur |
| | | |
| | | |

| **19.** If you were convicted of an indictable offense for possession or use, have you enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program? | | **[ ] Yes [ ] No** |
|---|---|---|
| Individual Receiving Treatment | Treatment Facility | Date of Treatment |
| | | |
| | | |

**19. a.** If you have not enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program, what is the reason?

_____
_____
_____.

**20.** Has anyone in the household voluntarily quit a job?

In the last 90 days for WFNJ **[ ] YES [ ] NO** If **YES**, Who? _____.
In the last 60 days for NJ SNAP **[ ] YES [ ] NO** If **YES**, Who? _____.
If **YES**, Why? _____.
**21.** Is anyone in your household on strike? **[ ] YES [ ] NO** If **YES,** Who? _____.

**22.** What was the last date of employment? _____.

**22a.** What have you been doing since your last employment? _____
_____.

**23.** For WFNJ purposes only, list all employment for each person applying for assistance in the last 3 years, starting with the most recent.

| Name | Name of Employer | Address of Employer | Start Date | End Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**24.** Does any member of the applicant household expect any change in circumstances in the near future, such as a change in income; household size; change in residence; shelter costs; or the purchase or sale of an automobile?
**[ ] YES [ ] NO** If **"YES"**, What changes:_____
_____.

**25. EARNED INCOME:** Do you or anyone living with you get money from working, baby-sitting, your own business, odd jobs, selling, or other earned income? **[ ] YES [ ] NO** If **"YES**", provide the following information for each person:

| | | | |
|---|---|---|---|
| LAST NAME<br>FIRST NAME | | | |
| HOURS PER WEEK | | | |
| HOW OFTEN PAID | | | |
| EMPLOYER'S NAME AND ADDRESS OR "SELF" IF SELF-EMPLOYED | | | |
| PAY (BEFORE ANY PAID DEDUCTIONS)<br>GROSS AMOUNTS AND DATES | DATE AMOUNT | DATE AMOUNT | DATE AMOUNT |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**26. CHILD/ADULT CARE:** Did anyone included in your welfare or NJ SNAP household pay for child care or adult care because of a job, going to school, or looking for work? **[ ] YES [ ] NO** If "**YES"**, who was cared for? (List Below)

| NAME OF CHILD/ADULT | CARE PROVIDED BY (PERSON) | DAYS PER WEEK | HOURLY RATE | TOTAL DAYS | ACTUAL AMOUNT PAID/ BY WHOM |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

| **VERIFICATIONS** |
|---|
| |

**27. CHILD SUPPORT:** Are you legally obligated to pay or provide child support to a child outside of your household?
**[ ] YES [ ] NO** If "**YES"**, complete the following information: (Include payments for child support arrearages, as long as you are legally obligated to pay them.)

| TO WHOM | ADDRESS | AGE OF CHILD | MO. AMOUNT PAID/ PROVIDED | COURT ORDER NUMBER |
|---|---|---|---|---|
| | | | | |
| | | | | |

**28. HEALTH INSURANCE:** Who is covered by health insurance? **IF NONE, CHECK ( ) HERE.**

| LAST NAME, FIRST NAME | INSURANCE COMPANY | POLICY NUMBER | POLICY HOLDER |
|---|---|---|---|
| | | | |
| | | | |

**29.** Does an absent spouse have medical or health insurance coverage for you? **[ ] YES [ ] NO** If **"YES",** what insurance? _____.

**30.** Does any absent parent have medical or health insurance coverage for any of the children for whom you are applying?
**[ ] YES [ ] NO** If **"YES",** what insurance, and for whom? _____
_____.

**31.** Have you or your household members applied for other Medicaid programs? If **"YES",** which program? _____**.** Date you applied _____.

**32. OTHER INCOME:** Do you or anyone included in your welfare or NJ SNAP household (including stepparents) receive or applied for any of the following: **YES ___ NO___ IF YES, CHECK ALL THAT APPLY.**

| | | | | | |
|---|---|---|---|---|---|
| | Unemployment Insurance | | Income from Property Rent | | Workers' Compensation |
| | Veterans' Benefits | | Income from Roomer(s) and/or Boarders | | Union/Pension Benefits |
| | Social Security/Railroad Retirement | | Income from Relative, Friend, Lodges or Unions | | Child Support |
| | Supplemental Security Income (SSI) | | Income Tax Refund or Earned Income Credit | | Allotment Check from a Serviceman |
| | Disability Payments | | Foster Care Payments | | General Assistance |
| | Subsidized Adoption | | Trust Fund | | Training Allowance |
| | Interest/Dividends from Stocks, Bonds, Bank Accounts, etc. | | Lump Sum Payments (from Retroactive Benefits, Money from Lawsuits, etc.) | | Student Loans, Grants, Scholarships, or Stipends |
| | Annuity Benefits (Include Life Insurance Dividends) | | Lump Sum Earnings, Winnings, or Gifts | | Supplemental Work Support |
| | DCP&P Relative Care Permanency Support | | DCP&P Legal Guardianship Subsidy Programs | | Other Income, such as, alimony (Specify): |

Give the following information for the items checked above:

| Last Name, First Name | Source of Income | Dates Received | Total Amount |
|---|---|---|---|
| | | | |
| | | | |

**VERIFICATIONS**

**33.** RESOURCES**: (Does apply to NJ SNAP households not eligible for expanded categorical eligibility**) Do you or anyone living with you have cash, checking, or savings accounts, stocks, bonds, C.D.'s, IRA's/Keogh, mutual funds, trust funds, U.S. Savings Bonds, Christmas/vacation or other club savings accounts, Credit Union membership, money or valuables in a safe deposit box, notes or contracts of value, ownership of mortgages or other resources? **[ ] YES [ ] NO**

| Person Who Owns Resource | What is the Resource? | Where is the Resource? | How Much is the Resource Worth? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**VERIFICATIONS**

**34.** List all vehicles owned by persons in the applicant household. Include all types of transportation such as cars, vans, tractor trailers, pick-up trucks, trailers, motor homes, motorcycles, boats, etc. **IF NONE, CHECK ( ) HERE.**

| Owner's Name | Model/Style | Year/Make | Use | Kelley Bluebook Value |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**35.** Do you or does anyone living with you own any land or real estate other than the house you live in? **[ ] YES [ ] NO**
If **"YES",** explain: _____
_____.

**36.** Did anyone trade, give away, transfer or sell real or personal property (including stocks):
For TANF and GA purposes within the past 12 months? **[ ] YES [ ] NO**
For NJ SNAP purposes within the past 3 months? **[ ] YES [ ] NO**

| What was sold, given away, etc.? | By Whom? | To Whom? | Date of Gift or Sale? | Total Market Value | Amount Received |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**37.** Do you, or anyone included in your applicant household, have any pending claims such as lawsuits, divorce, settlements, inheritance, accident claims, sale of property, other claims, or does anyone owe you or them money? **[ ] YES [ ] NO**
If **"YES"**, explain: _____.
_____.

**DATE WFNJ-10D COMPLETED** _____. **(Does not apply to NJ SNAP only clients)**

**38.** Does anyone in the applicant household have: **(Does not apply to NJ SNAP)**

**(a)** Part or full ownership of valuable personal property such as jewelry, coin/stamp collections, furs, etc.?
**[ ] YES [ ] NO** If **"YES",** Explain _____.

**(b)** A burial plot or arrangement ? **[ ] YES [ ] NO If "YES", VALUE** _____.

**NJ SNAP AND GA**

**SHELTER INFORMATION:** To be completed if household is applying for participation in the NJ SNAP Program and/or GA.

**39.** Does anyone outside of the household pay or assist with payments of any household expenses? **[ ] YES [ ] NO**
If "**YES",** complete below:

| TYPE OF SHELTER EXPENSE | PAID TO WHOM | PAID BY | AMOUNT PAID | HOW OFTEN BILLED |
|---|---|---|---|---|
| | | | | |
| | | | | |

**40. SHELTER COSTS** (List household expenses for the following:)

| SHELTER EXPENSE | AMOUNT PAID | HOW OFTEN BILLED | FOR OFFICE USE ONLY MONTHLY COST | |
|---|---|---|---|---|
| **Rent/Mortgage** | $ | | $ | If using |
| **Property Taxes** | $ | | $ | HCSUA |
| **Insurance on Home** | $ | | $ | |
| | **SHELTER SUBTOTAL** | | $ | |
| | | | | |
| **Electricity** | $ | | $ | |
| **Gas** | $ | | $ | |
| **Oil** | $ | | $ | |
| **Water** | $ | | $ | |
| **Sewerage** | $ | | $ | |
| **Garbage/Trash Removal** | $ | | $ | |
| **Cost of Installation of Utilities** | $ | | $ | |
| **Other (Coal, Wood, Kerosene)** | $ | | $ | HCSUA |
| | **UTILITIES SUBTOTAL** | | $ or | |

**41A**. Do you pay for utilities (separate from your rent) to heat or cool your house?
**[ ] YES [ ] NO**

**41B.** If your household is responsible for payment of utilities in addition to water, sewerage, and garbage removal, your household may qualify to choose to receive either the **standard or heating utility allowance.**

$
**or**

**MONTHLY . TOTAL. SHELTER**
**DATE OPTION SELECTED**

**42. EXCESS MEDICAL COSTS**

Is anyone in your household 60 years of age or older, and/or certified for Federal Supplemental Security Income (SSI), Social Security Disability or Veteran's payments? **[ ] YES [ ] NO** If "**YES**", complete the following. If "**NO**", continue on Page 12. Medical expenses may include amounts which have been billed, even if you have not actually paid the medical bill.

| Besides regularly occurring medical expenses, list those other medical services which you may have required. | **Amount Paid** | **How Often Billed** | **FOR OFFICE USE ONLY Monthly Total** | **VERIFY RECEIPT OF SSI** |
|---|---|---|---|---|
| Medical and Dental Services | $ | | $ | _____ FEDERAL SHARE |
| Hospital or Nursing Care | $ | | $ | |
| Drugs Prescribed by a Doctor | $ | | $ | |
| Dentures, Hearing Aids and Eye Glasses | $ | | $ | |
| Transportation Costs to Get Medical Care | $ | | $ | |
| Services of an Attendant or Nurse | $ | | $ | |
| Other (Explain) | $ | | $ | |
| | | | $ | **SSA and SSI Listed on Page 6** |

**42A.** List the names of household members who have these expenses:

**TOTAL**

**42B.** Are any of the medical expenses you've listed above paid for, partially paid for or reimbursed by another source outside of your household such as medical insurance, Medicare, PAAD or another individual?
**[ ] YES [ ] NO** If "**YES**", which expense(s) do they pay? How much do they pay?

_____

_____

_____

| **FOR OFFICE USE ONLY**<br><br>WORK FIRST NEW JERSEY AND/OR NJ SNAP WORK REGISTRATION | | | | | | |
|---|---|---|---|---|---|---|
| NAMES (ALL OVER 16) | EXEMPT WFNJ CODE | MANDATORY WFNJ DATE | VOLUNTARY WFNJ DATE | REFERRAL DATE | NJSNAP WORK EXEMPT CODE | DATE OF REG. |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**43. HOME ENERGY ASSISTANCE**

Your answer to the following question will be used to determine eligibility for Home Energy Assistance (HEA) and the amount of HEA benefits. Using the list below, indicate which item best describes your heating/living arrangement.

( ) My heat is paid for by others. **(A)** **HEA CODE: _____**

( ) My heat is provided by a public housing authority or I received a rent subsidy, and my heat is included in my rent. **(C)**

( ) I pay only for a secondary source of heat (such as a wood stove, kerosene heater, electric space heater, etc.). **(E**)

( ) I share the cost of heat with others. **(F)**

( ) My heat is included in my rent, which is not subsidized. **(G)**

( ) I pay a separate charge to my landlord for heat. **(W)**

I pay my fuel supplier directly for the primary source of heat for my house or apartment. My source of heat is:

( ) fuel oil **(J)** ( ) kerosene **(M)** ( ) wood **(R)**

( ) electricity **(K)** ( ) natural gas **(N)**
( ) bottled gas **(L)** ( ) coal **(P)** ( ) I do not wish to receive HEA benefits. **(T)**

## IMPORTANT NOTICE

**THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND/OR COUNTY OFFICIALS. IF ANY IS FOUND INCORRECT, YOU MAY BE DENIED NJ SNAP BENEFITS AND/OR SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.**

**In order to comply with 45 CFR 206.10(a)(iii) and 7 CFR 273.2(b), we are notifying you that income and eligibility information for BCIS, State and local child support agencies, Social Security Wage and Benefit files, and State Wage and Unemployment files will be obtained using your Social Security Number(s) and will be used in the determination of your continuing eligibility. This may involve our contacting your employer, bank, or other party.**

**THE PENALTIES PROVIDED BELOW APPLY TO THE FOLLOWING:**

**ANY NJ SNAP RECIPIENT WHO INTENTIONALLY BREAKS ANY OF THE RULES LISTED ON THE APPLICATION; OR**

**ANY PERSON WHO APPLIES FOR OR RECEIVES NJ SNAP BENEFITS TO WHICH THEY ARE NOT ENTITLED BY HAVING INTENTIONALLY:**

**MADE A FALSE OR MISLEADING STATEMENT.**

**CONCEALED OR WITHHELD FACTS.**

- **COMMITTED ANY ACT WHICH CONSTITUTES A VIOLATION OF THE FOOD STAMP ACT, NJ SNAP PROGRAM REGULATIONS OR ANY STATE LAW RELATING TO THE USE, PRESENTATION, TRANSFER, ACQUISITION, RECEIPT OR POSSESSION OF NJ SNAP BENEFITS OR ACCESS DEVICES (SUCH AS FAMILIES FIRST EBT CARDS).**

## PENALTIES

**THE PENALTIES FOR INTENTIONALLY VIOLATING SNAP RULES INCLUDE A DISQUALIFICATION FROM PARTICIPATING IN SNAP FOR THE FOLLOWING TIME PERIODS**

- **12 MONTHS for a first offense;**
- **24 MONTHS for a second offense, OR the first court conviction for trading SNAP benefits for a controlled substance;**
- **10 YEARS for lying or misrepresenting information about the identity or residence of an individual to receive multiple SNAP benefits at the same time;**
- **PERMANENTLY for a third offense, OR a second court conviction for trading SNAP benefits for a controlled substance, OR a court conviction for selling/trading SNAP benefits of $500 or more, OR a court conviction for trading SNAP benefits for firearms, ammunition or explosives.**

***AN ADDITIONAL 18 MONTHS SUSPENSION (CONSECUTIVE TO THIS PERIOD) MAY BE IMPOSED BY THE COURT FOR ANY PERSON CONVICTED OF FELONY OR MISDEMEANOR VIOLATION.**

**THE VIOLATOR MAY BE FINED UP TO $250,000, IMPRISONED UP TO 20 YEARS, OR BOTH, AND SUBJECT TO PROSECUTION UNDER OTHER APPLICABLE FEDERAL LAWS.**

**IN ADDITION, THE REMAINING HOUSEHOLD MEMBERS WILL BE REQUIRED TO REPAY ANY NJ SNAP BENEFITS THE HOUSEHOLD RECEIVED TO WHICH IT WAS NOT ENTITLED.**

**P.L. 103-66 AND 104-193 ESTABLISHED PENALTIES FOR INDIVIDUALS WHO ARE FOUND GUILTY IN A FEDERAL, STATE, OR LOCAL COURT OF:**

1) **TRADING NJSNAP BENEFITS FOR FIREARMS, AMMUNITION, EXPLOSIVES, OR CONTROLLED SUBSTANCES; OR**

2) **USING, TRANSFERRING, ACQUIRING, OR POSSESSING NJ SNAP BENEFITS, THROUGH THE USE OF FAMILIES FIRST EBT CARDS, OR PRESENTING NJ SNAP BENEFITS FOR PAYMENT KNOWING SAME TO HAVE BEEN FRAUDULENTLY OBTAINED OR TRANSFERRED, IF THE VALUE IS $500 OR MORE.**

## PENALTY WARNING

**DON'T give false information, or hide information, in order to apply for or receive or continue to receive NJ SNAP benefits.**

**DON'T give or sell NJ SNAP benefits or access through the use of Families First EBT cards to anyone who is not authorized to use them for your household.**

**DON'T use any NJ SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco, or to pay for food that was purchased on credit.**

**DON'T use any NJ SNAP benefits your household was not entitled to receive.**

**DON'T cheat or take part in any dishonest act to get NJ SNAP benefits your household isn't entitled to receive.**

**DON'T transfer resources to a non-household member in order to apply for and receive NJ SNAP benefits.**

**I understand the questions on this application. My answers are correct and complete to the best of my knowledge and belief. I understand that I must be interviewed, and that I must cooperate with the NJ SNAP office. I understand the penalty warning. I understand that I may have to provide documents to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the NJ SNAP office may contact to obtain the necessary proof. I understand that if I have not reported any earned income, then I must report any change in unearned income of more than $50.00, or the receipt of earned income within 10 days of the date of my first paycheck. I understand that if I have no earned income, I must report all changes in household composition (including student status), changes in residence and the resulting change in shelter costs, changes in my legal obligation to pay or provide child support, a change in the amount of child support I provide if I have less than a 3-month record of paying it and the change is greater than $50.00, a purchase of a vehicle or an increase in my household's resources (savings and checking account, cash on hand, stocks or lump sum payments, any cash deriving from the sale or trade of a vehicle) if they reach or exceed my maximum resource limit. I understand that if I reported earned income, or I am on a six-month reporting, I am only required to report a change in my monthly total income that exceeds 130 percent of the federal poverty level limit. My worker will provide me with a notice of that limit. I also understand that I may request a fair hearing of the decision made on my application for NJ SNAP benefits. If I need more information concerning NJ SNAP benefits, I can contact the county NJ SNAP office.**

**I understand that I, or my representative, may request a fair hearing, either orally or in writing, if I disagree with any action taken on my case. My case may be presented at the hearing by any person I choose.**

### NJ SNAP MANDATORY EMPLOYMENT AND TRAINING PARTICIPANTS

**Certain NJ SNAP household members, unless specifically exempted, are required to register for and participate in Employment and Training activities. Mandatory registrants who fail to comply with work requirements will be subject to the following penalties:**
**1) The 1st violation results in a minimum disqualification of 1 month;**
**2) The 2nd violation results in a minimum disqualification of 3 months;**
**3) The 3rd, and subsequent violations, result in a minimum disqualification of 6 months.**

### U.S. CITIZENSHIP/LEGAL ALIEN STATUS
### (FOR WFNJ AND NJ SNAP PROGRAM PURPOSES)

**For each person who is not a U.S. citizen, you will need to show the county welfare agency office either documentation from the Bureau of Citizenship and Immigration Service (BCIS) or other documents the State agency determines are proof of your immigration status. Alien status may be subject to verification with the BCIS which will require submission of certain information from this application form to the BCIS. Information received from the BCIS may affect your household's eligibility and level of benefits. You must certify that each household member is a U.S. citizen or is living in the U.S. in lawful immigration status.**

**BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK.**

- I (we) agree that the statements that I (we) made on this form are true and complete to the best of my (our) knowledge. I (we) know that lying about my (our) situation, failing to give the necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.
- I (we) understand that any information I (we) give is subject to verification by the County Welfare Agency, and/or the Division of Family Development.
- I (we) hereby authorize the County Welfare Agency or the Division of Family Development to contact any individual or other source who may have knowledge about my (our) circumstances (to include IRS, State and local child support agencies, Social Security Wage and Benefit files, State Wage and Unemployment files, credit reporting services, as well as employers, banks or other parties) for the sole purpose of verifying the statements I (we) have made. I (we) understand that any income and eligibility information obtained will be used to determine my (our) continuing eligibility.
- I (we) understand that, in accordance with Work First New Jersey Act, Public Law 1997 c.13, c.14, c.37 and c.38, application for public assistance will include all future members of the budget unit required to be included, whether by birth, adoption, or by beginning to live with the budget unit after the date of the original application.
- I (we) know that any information I (we) give will be used in connection with my (our) application for public assistance, NJ SNAP benefits, home energy assistance benefits, Universal Service Fund benefits and other benefits for which I may be eligible.
- I (we) understand that if this application is accepted for the WFNJ category, that I (we) and all members of my (our) household are enrolled in the New Jersey One Stop Career Center and may be required to participate in education, training, vocational assessment and job placement activities.
- I (we) understand that all home energy assistance payments are subject to the availability of federal funds.
- I (we) understand that all home energy assistance payments made are to be used toward the purchase of heating/cooling energy.
- I (we) have received and had explained to me (us), if necessary, information concerning my rights and responsibilities. (See WFNJ Handbook.)
- I (we) agree to let the County Welfare Agency know immediately of any change in living conditions, family situation or money received (except for earned income that is subject to six-month reporting requirements) from any source, when applicable. (See WFNJ Handbook.)
- I (we) understand that I (we) or my (our) representative may request a fair hearing, either orally or in writing, if I (we) am (are) not satisfied with any action taken by the County Welfare Agency. My (our) case may be presented at the hearing by any person I (we) choose.
- I (we) understand that upon signing this application for WFNJ purposes only, I (we) assign to the County Welfare Agency any right to support, including any arrears that have accrued, from any other person for myself or any other family member for whom I (we) am(are) applying for or receiving aid.

*This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

**COMPLETE BEFORE SIGNING**

I (WE) have read the Important Notice on Page 10 of this form referring to the NJ SNAP penalty warnings and Citizenship/Legal Alien Status. ( ) YES ( ) NO

- I (we) attest that I (we) have read and agree to these statements and fully realize that the Welfare Agency relies upon the truth and accuracy of my (our) statements.
- I (we) certify, under penalty of perjury, by signing my (our) name(s) below, that I (we) and all household members for whom I (we) am (are) applying for NJ SNAP benefits are U.S. citizens or aliens in lawful immigration status.
- I (we) certify under penalty of perjury that my (our) answers regarding application for the NJ SNAP Program and/or the WFNJ program are correct and complete, to the best of my (our) knowledge.
- I (we) have received an orientation to the WFNJ work requirements by the agency representative, if applicable.

SWORN AND SUBSCRIBED BEFORE ME

Applicant Signature Date

This_____Day _____2__

Co-Applicant Signature Date

_____

(Agency Representative)

# IMPORTANT NOTICE
# NJ SNAP INCOME DEDUCTION WAIVER

**IF YOU FAIL TO REPORT OR VERIFY ANY OF THE FOLLOWING EXPENSES WHICH EITHER YOU OR ANOTHER HOUSEHOLD MEMBER IS PAYING, WE WILL TAKE THIS TO MEAN THAT YOU DO NOT WANT TO RECEIVE AN INCOME DEDUCTION FOR THOSE UNREPORTED EXPENSES.**

- A DEPENDENT CARE EXPENSE, IF YOU ARE PAYING FOR THE CARE OF A CHILD OR OTHER DEPENDENT SO THAT A HOUSEHOLD MEMBER CAN WORK, SEEK EMPLOYMENT, OR ATTEND TRAINING OR EDUCATION CLASSES IN ORDER TO PREPARE FOR EMPLOYMENT;

- AN UNREIMBURSED MEDICAL OR DENTAL EXPENSE, INCLUDING PRESCRIBED MEDICATION, HEALTH OR HOSPITALIZATION INSURANCE, EYE GLASSES, OR ATTENDANT CARE;

- A CHILD SUPPORT PAYMENT WHICH A HOUSEHOLD MEMBER IS MAKING UNDER A LEGAL OBLIGATION, INCLUDING PAYMENTS ON ARREARS; OR

- A SHELTER EXPENSE, SUCH AS RENT, UTILITIES (INCLUDING INSTALLATION CHARGES), PROPERTY TAXES, HOMEOWNER'S INSURANCE, AND CHARGES FOR REPAIR OF YOUR HOME DUE TO A NATURAL DISASTER.

EVEN IF YOU DO NOT TELL US (OR VERIFY) THAT YOU ARE INCURRING ONE OF THESE EXPENSES WHEN YOU APPLY FOR NJ SNAP, YOU MAY STILL RECEIVE AN INCOME DEDUCTION LATER IF YOU TELL US (OR VERIFY) THAT YOU ARE PAYING ONE OF THESE EXPENSES. THE DEDUCTION WILL NOT BE RETROACTIVE FOR THOSE MONTHS THAT YOU DID NOT TELL US THAT YOU WERE PAYING THE EXPENSES.

**HEAD OF HOUSEHOLD SIGNATURE** _____

**TODAY'S DATE** _____

**FORM WFNJ-1J ADDENDUM "A"**
**NOTICE**

In order to be eligible for Work First New Jersey, an applicant must sign an agreement to repay as required by Public Law 1997, Chapters 14 and 38. If you choose not to sign this agreement, **All** members of your household assistance unit will not be eligible for Work First New Jersey assistance.

**AGREEMENT TO REPAY**

**CASE NO. _____ _____ COUNTY/MUNICIPAL AGENCY**

**I, _____, living at _____**

_____

Have read, or have had read or interpreted to me, the explanation of my rights and responsibilities for repayment of assistance granted to me and/or other members of my household as stated in this agreement and I understand them.

I am applying for assistance for myself and/or other members of my household under the Work First New Jersey Program. I understand that if I receive any lump sum of money or income, other than earnings, that may be available to me or my household assistance unit, Public Law 1997, Chapters 14 and 38 require me to repay from some or all of the assistance I or my household assistance unit have received from Work First New Jersey. The lump sum of money or income, other than earnings, that is used to repay assistance may include, but is not limited to, lump sum money or income, other than earnings, that I or members of my assistance unit may not know about, such as inheritances, lottery winnings, casino winnings, racetrack winnings, and personal injury settlements or awards from lawsuits.

I understand that the following benefits, by law, do not have to be used to repay assistance: RSDI, Railroad Retirement, Veteran's benefits, Workman's Compensation, Temporary Disability through the NJ Department of Labor and Workforce Development, term life insurance and for TANF recipients only, SSI. Recipients of GA must sign a WFNJ/GA-30 and WFNJ-30A for repayment of GA benefits from their SSI award.

I agree to repay the county/municipal agency an amount equal to the cash assistance and/or emergency assistance granted to me or my household assistance unit if I or an assistance unit member receive such a lump sum of money or income.

I understand that repayment of cash assistance and/or emergency assistance in full to the county/municipal agency means that the months of assistance I repaid will not count toward the 60-month time limit on receipt of Work First New Jersey assistance.

I agree to authorize and direct any legal counsel I may have to inform the county/municipal agency about the lump sum of money or lump sum of income, and to repay the agency from the amount received and/or available.

I agree to report to the county/municipal agency any information I receive about the lump sum of money or income. I agree to notify the county/municipal agency within 10 calendar days of receiving such a lump sum of money or income.

I understand that I have the right to request from the county/municipal agency that the repayment be delayed, reduced or eliminated pursuant to N.J.S.A. 44:10-64 and implementing regulations at N.J.A.C. 10:90-7.8.

| _____ | _____ | _____ |
|---|---|---|
| Client's Signature | Date | Witness |
| _____ | _____ | _____ |
| Client's Signature | Date | Witness |

## EXPLANATION OF AGREEMENT TO REPAY

In order to be eligible for Work First New Jersey benefits under the Work First New Jersey Program, Public Law 1997, Chapters 14 and 38, require that every applicant sign an agreement to repay the cash assistance and/or the emergency assistance granted to them and their household assistance unit if a lump sum of money or income, other than earnings, is owed to them or becomes available to them, unless the lump sum is specifically earmarked for payment of medical bills, funeral or burial expenses, replacement or repair of resources, or similar payments.

The Agreement to Repay is your agreement to repay the cash assistance and/or emergency assistance you will receive in exchange for the agency's agreement to give you the benefits and services available under the Work First New Jersey Program within the time limits of the program.

You are agreeing to report to the county/municipal agency any information about the receipt of any lump sum of money or lump sum of income, or have your legal counsel do so. You must notify the county/municipal agency within 10 days of its receipt if you have received a lump sum.

If you have repaid in full the cash and/or emergency assistance received under the Work First New Jersey Program, the months of assistance repaid will not count toward your 60-month time limit for assistance. You also have the right to seek to delay, reduce or eliminate the repayment by a request for such from the agency, pursuant to N.J.S.A. 44:10-64 and implementing regulations at N.J.A.C. 10:90-7.8(e).

**********

COMPLETE THIS PORTION ONLY IF THE CLIENT HAS REPORTED A PENDING LAWSUIT, CLAIM OR OTHER INTEREST.
FORWARD ORIGINAL TO THE LEGAL UNIT WITH A COPY TO THE CASE FILE.

_____ Accident _____ Date & Place of Accident

_____ Name of Injured Person

_____ Inheritance _____ Name of Deceased
(Attach copy of Will, if available)

_____ Date of Death

_____ Beneficiary

_____ Sale of Property _____ Realtor
(Attach copy of Listing Agreement, if available)

_____ Date Property Listed

_____ Pending Lawsuit _____ Date of Lawsuit

_____

_____ Other _____
(Describe)

_____

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

_____

ATTORNEY'S TELEPHONE NUMBER: _____

_____ _____ _____ _____
Client's Signature Date Witness Date

_____ _____ _____ _____
Client's Signature Date Witness Date

**FORM WFNJ-1J ADDENDUM "B" (Revised 09/16)**

**I (we) understand that, if this application is accepted for WFNJ/TANF, the birth of a child(ren) after 10 months from the date of initial application will not entitle me(us) to an increase in my(our) cash assistance benefits amount. I(we) understand that the 10-month period from the date of application shall include any voluntary case closing or temporary penalty periods that may be imposed on me(us) for noncompliance with the WFNJ/TANF program eligibility requirements. I understand that this child(ren) may be eligible for NJ SNAP and child care payments. I(we) understand that I(we) assign any right to support, including any arrears, that have accrued from any other person for this child(ren).**

| | |
|---|---|
| **Applicant Signature** | **Date** |
| **Co-Applicant Signature** | **Date** |
| **Agency Representative** | |

**Sworn and subscribed**

**before me this _____day**

**of _____20___**

# 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 received this Voter Registration Opportunity form in the mail, as part of a take home packet, or during a home visit, please complete it and return it to your local County Welfare Agency (Board of Social Services). Do not send this Voter Registration Opportunity form to the Division of Elections.

Once you complete the actual Voter Registration Application, return the application directly to your County Welfare Agency or to the Division of Elections. If you would like help filling out the Voter Registration Application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. For assistance with the Voter Registration Application contact your local County Welfare Agency.

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, www.elections.nj.gov.

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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 or Non-Affiliation Change ☐ Name Change ☐ Signature Update

**FOR OFFICIAL USE ONLY**

Clerk

Registration #

Office Time Stamp

☐ by mail
☐ in person

**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)*

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

**4** Date of Birth

**5** NJ Driver's License Number or MVC Non-driver ID Number

If you DO NOT have a NJ Driver's License or MVC Non-Driver ID, provide the last 4 digits of your Social Security Number. ___ ___ ___ ___

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

☐ "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)* | | | | | |

**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

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

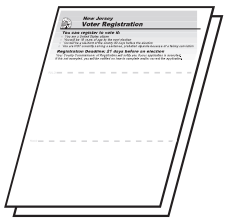
**BUSINESS REPLY MAIL**
FIRST-CLASS MAIL PERMIT NO. 206 TRENTON, NJ

POSTAGE WILL BE PAID BY ADDRESSEE

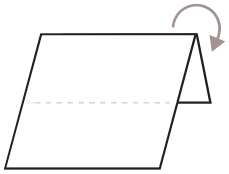
DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

**2** FOLD

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

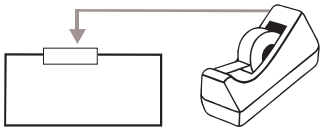


Put both pages together as shown



**1** fold top down

**2** fold bottom up



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