



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

NJ FamilyCare Aged, Blind, Disabled Programs

APPLICATION

SECTION 1 Applicant

Applicant's Name: _____
Last First Middle Maiden Name

Home Address: _____
Street City State Zip Code

Current Mailing Address (if different from above):

Street City State Zip Code

Is Applicant living in a nursing facility? ☐ Yes ☐ No

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

Street City State Zip Code

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

Applicant's E-mail Address: _____

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

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

Does the Applicant have a history of a severe or chronic intellectual disability
or developmental disability that occurred before age 22 and is indicated by
intellectual disability, autism, cerebral palsy, epilepsy, spina bifida or
other neurological impairments? ☐ Yes ☐ No

Does the Applicant need "nursing home like" services, Long Term Services and
Supports, such as dressing, bathing or mobility assistance? See Brochure. ☐ Yes ☐ No

Has the Applicant ever applied before?
☐ Yes If yes, which county _____ ☐ No

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HMO choice	_____
Date Applied	_____
Case #	_____

NJFC-ABD-AP-1119

SECTION 2 Demographic Information for the Applicant

Date of Birth: _____ - _____ - _____ Sex: ☐ Male ☐ Female
Month Day Year

Citizenship Status: ☐ US Citizen ☐ Lawful Permanent Resident ☐ Refugee
☐ Asylee ☐ Not Lawfully Admitted ☐ Legal Immigrant _____
Date of Entry

USCIS/Alien # _____ Immigration Card # _____

Official Name on Immigration Document/Card (AKA) _____

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

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

SECTION 3 Spouse's Name Also include if divorced, separated or widowed.

Spouse's Name: _____
Last First Middle Maiden Name

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

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

Spouse's Address (last known) _____
Street City State Zip Code

Is this person also applying for the Aged, Blind, Disabled Programs?
☐ No ☐ Yes, please complete the Spouse Information form.

SECTION 4 Assistance with Application

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

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

Provide the following information for this person:

Name _____

Address _____
Street City State Zip Code

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

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Date Applied _____
 Case # _____

SECTION 5 Health Insurance Information

☐ **Medicare Part A** Date Eligible _____

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

☐ **Medicare Part B** Date Eligible _____

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

☐ **Medicare Part C** Date Eligible _____

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

☐ **Medicare Part D** Date Eligible _____

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

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

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

Name of Policy	Policy Number	Policy Premium

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

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

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

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Date Applied _____

Case # _____

SECTION 6 Living Arrangements

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

- ☐ Home: Own ☐ Rent ☐ Living with Spouse ☐ Nursing Facility
☐ Assisted Living Facility ☐ Residential Care Facility
☐ Renting a room(s) in another person's residence ☐ Living with Relative or Friend
☐ Other: Living Arrangement: _____

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

SECTION 7 Income Information

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

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

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

Current Job & Income Information

Does the Applicant have any income from employment?

☐ Yes ☐ No

☐ **Employed**

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

☐ **Self-employed**

Skip to question 10.

☐ **Not employed**

Skip to question 11.

CURRENT JOB 1:

1. Employer name and address _____

2. Employer phone number (____) _____ - _____

3. Work Income (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks

☐ Twice a month ☐ Monthly ☐ Yearly \$ _____

4. Average hours worked each WEEK _____

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Date Applied _____

Case # _____

CURRENT JOB 2:

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

5. Employer name and address _____

6. Employer phone number (____) _____ - _____

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

8. Average hours worked each WEEK _____

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

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

a. Type of work _____

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

11. OTHER INCOME:

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

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

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

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



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

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

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Date Applied _____

Case # _____

SECTION 7a Spouse's Income

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

Current Job & Income Information

☐ **Employed**

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

☐ **Self-employed**

Skip to question 22.

☐ **Not employed**

Skip to question 23.

CURRENT JOB 1:

13. Employer name and address _____

14. Employer phone number (____) _____ - _____

15. Work Income (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly
 \$ _____

16. Average hours worked each WEEK _____

CURRENT JOB 2:

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

17. Employer name and address _____

18. Employer phone number (____) _____ - _____

19. Work Income (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly
 \$ _____

20. Average hours worked each WEEK _____

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

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

a. Type of work _____

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

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Date Applied _____

Case # _____

23. **OTHER INCOME:**

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

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

24. **YEARLY INCOME:**

Complete only if your income changes from month to month.

If you don't expect changes to your Spouse's income, skip to the next page.



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

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

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Date Applied _____

Case # _____

SECTION 8 Resources for Applicant and Applicant's Spouse

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

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

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

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

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

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

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Date Applied _____
Case # _____

Application for Aged, Blind and Disabled Programs

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

No Investments ☐

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

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

No Property ☐

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

FOR OFFICE USE ONLY

Date Applied _____
Case # _____

LIFE INSURANCE POLICIES

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

No Life Insurance ☐

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

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

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

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

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

No Vehicles ☐

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

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

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

FOR OFFICE USE ONLY

Date Applied _____
Case # _____

TRUSTS

Testamentary Trust ☐ Special Needs Trust ☐ Qualified Income Trust ☐

Grantor _____

Trustee _____

Beneficiary _____

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

Tax ID# _____ Date trust was initially funded _____

Burial Arrangements

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

☐ Yes If yes, please send contract. ☐ No

☐ Burial plots

☐ Account set aside for burial Account # _____ Value _____

Identified Funeral Home (name and address) _____

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

OTHER RESOURCES NOT LISTED _____

Has the Applicant established a Plan of Liquidation for any of the resources in Section 8?

☐ Yes ☐ No

SECTION 9 Transfers

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

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

Item Transferred _____ Transfer Date _____

Market Value _____ Amount Received _____

Item Transferred _____ Transfer Date _____

Market Value _____ Amount Received _____

Item Transferred _____ Transfer Date _____

Market Value _____ Amount Received _____

FOR OFFICE USE ONLY

Date Applied _____

Case # _____

SECTION 10 Legal Issues

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

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

Attorney's Name _____

Attorney's Phone Number (____) ____ - ____

Attorney's Address _____

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

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

If yes, provide details regarding these arrangements. _____

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

☐ Yes ☐ No

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Date Applied _____

Case # _____

SECTION 11 Select the Applicant's Health Plan

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



Choose One:

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

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

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

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Date Applied _____

Case # _____

SECTION 12 Applicant and Beneficiary 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.

- 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 New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) for the Medicaid/NJ FamilyCare program, which is called **"NJ FamilyCare"** in this application. I understand that my medical benefits may be reduced, denied, or stopped because of information received through this verification.
- I understand that my situation is subject to verification from employers, financial sources and other third parties. I hereby give permission to NJ FamilyCare to contact any individual or other source that may have knowledge about my circumstances, or the circumstances of a person necessary for this application, for the purpose of verifying the statements I have made. I give third parties permission to share information about me with authorized State, State contractor, and county staff conducting investigations. 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 necessary. I further authorize taxing authorities to release my tax information and copies of my tax returns.
- I understand that the DMAHS eligibility determining agencies and government contractors may exchange information relating to coverage to assist with this application, enrollment, administration, and billing services.
- I understand that DMAHS has the authority to file a claim and lien against the estate of a deceased Medicaid beneficiary, or former beneficiary, to recover all NJ FamilyCare payments made on the beneficiary's behalf to pay for health care coverage on or after age 55, regardless of whether services were received. A NJ FamilyCare beneficiary's estate may be required to pay back DMAHS for those benefits. This includes monthly payments to, for example, a managed care entity to secure health coverage that you may not use in any month. More information about Estate Recovery is available online at:
www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf

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Date Applied _____

Case # _____

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- I agree to tell the eligibility determining agency immediately of changes to information entered on this application, including but not limited to the following:
 - 1) If anyone receiving health benefits moves out of state;
 - 2) Changes in where we live, get our mail, or any other contact information;
 - 3) Changes in other health insurance coverage;
 - 4) Changes in income and/or resources;
 - 5) Improvement in medical condition, if disabled;
 - 6) Marriage, divorce, or death of spouse;
 - 7) Addition or loss of household member, including pregnancy;
 - 8) Sale or transfer of my home or other property;
 - 9) Lawsuits and inheritances.

I understand that failure to report changes in application information, including those changes listed above, may result in incorrectly paid benefits/coverage and I may have to reimburse the State of New Jersey for those benefits/coverage.

- I understand that the outcome of this application may be shared with any provider who provided services to the applicant/beneficiary during the period covered by the application.
- I understand, as a condition of being covered under Medicaid/NJ FamilyCare, that I have assigned to the Commissioner of the Department 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 including but not limited to other health insurance, legal settlements, or other third parties. 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 agree to help in obtaining medical support and payments from anyone who is legally responsible.
- I understand that I may request a fair hearing if I am not satisfied with the determination 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 resources, depending on the program. I understand that if I am seeking Long Term Services and Supports or services based on an institutional level of care, NJ FamilyCare will examine transfers of resources that occurred within the look back period before, and any time after, my first date of applying for benefits.

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Date Applied	_____
Case #	_____

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- In order to redetermine my eligibility for NJ FamilyCare in the future, I agree to allow NJ FamilyCare to use income data, including tax information. At time of renewal, NJ FamilyCare will send me a renewal notice and let me indicate any changes in my or my household's eligibility information, and I can withdraw my request for benefits in writing at any time.
- I understand that if some or all of the individuals applying do not qualify for NJ FamilyCare health coverage, that they may be eligible for federal benefits and/or may explore private health coverage options through the Federal Health Insurance Marketplace (Marketplace). If this is the case, I authorize NJ FamilyCare and its contractors to give information contained in this application to the Marketplace.
- I confirm that I have read and understood the NJ FamilyCare Privacy Policy available online at: <https://njfc.force.com/familycare/NJPrivacyNotice> and the Notice of Privacy Practices available online at: www.njfamilycare.org/docs/NJFC-HIPAA.pdf
- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if State or Federal privacy laws require or allow it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support.
- I will obey the law and regulations of the program.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can get more information, including how to file a complaint of discrimination by reading the NJ FamilyCare Non-Discrimination Statement available online at: www.njfamilycare.org/docs/ndc_english.pdf

NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7. The SSNs provided (including for a husband or wife, family members, or dependents) will be used to associate records pertaining to applicants and other persons necessary for the determination of eligibility, to verify identity, to verify income, to check other financial records such as bank account information, to the extent it is useful in verifying eligibility or the amount of medical assistance payments under 42 CFR 435.940 through 435.960, and preventing duplicate participation or incorrectly paid benefits for you and for persons in your household. The SSNs will be used in computer matching and program reviews or audits. These procedures are designed to determine eligibility and to identify persons who fraudulently or wrongfully participate in Medicaid and DMAHS programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.

FOR OFFICE USE ONLY	
Date Applied	_____
Case #	_____

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

SECTION 13 Applicant Signature

The person who filled out this application must sign this application. If you're an authorized representative you may sign here, as long as you have provided the Designation of Authorized Representative Form.

By signing below, I certify under penalty of perjury and false swearing that my answers on this application are true, correct and complete to the best of my knowledge. I also certify that:

- I understand the questions and statements on this application.
- I understand that I may be subject to penalties under federal and state law if I provide false or untrue information.

By signing below I also certify that I have read and understand the Applicant and Beneficiary Rights and Responsibilities included.

Applicant's Signature

Date (mm/dd/yyyy)

Authorized Representative Name

Relationship

Authorized Representative Signature

Date (mm/dd/yyyy)

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

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Date Applied _____

Case # _____

Intentionally left blank

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

NEW JERSEY COUNTY WELFARE AGENCIES

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

SUPPLEMENTAL INFORMATION

Designation of Authorized Representative Form

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

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

Name of Representative: _____

Company: _____

Address: _____

City, State, Zip: _____

Phone Number: (____) ____ - ____

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

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

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

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

 **SIGN ON BACK** 

Signatures

- _____
initial I understand that I may revoke this authorization at any time by notifying the Authorized Representative and the EDA in writing.
- _____
initial I understand that while this authorization is in effect, all notices/correspondence sent by DMAHS and the applicable EDA will only be sent to the Authorized Representative.
- _____
initial I understand that neither the State of New Jersey nor the EDA charge a fee to file a NJ FamilyCare application.

Signature of NJ FamilyCare Applicant
or Person Granting Authority

Date (mm/dd/yyyy)

Relationship (Self, Guardian, etc.)

Witness

Date (mm/dd/yyyy)

Print Name

Signature of Authorized Representative

Title (if employee of authorized company)

Print Name

Date (mm/dd/yyyy)

Witness

Date (mm/dd/yyyy)

Print Name

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

SUPPLEMENTAL INFORMATION

Spouse Information Form

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NJ FamilyCare Aged, Blind, Disabled Programs

SPOUSE INFORMATION *Complete Only if a Spouse is Applying*

SECTION 1 Applicant 2 (Spouse)

Applicant 1 Name:

Last First Middle Date of Birth (mm/dd/yyyy)

Applicant 2 (Spouse) Name:

Last First Middle Maiden Name

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

Street City State Zip Code

Current Mailing Address (if different from above).

Street City State Zip Code

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

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

Has the Applicant applied for Supplemental Security Income (SSI)?

☐ Yes If yes, when ____ - ____ ☐ No
Month Year

Does the Applicant have a history of a severe or chronic intellectual disability or developmental disability that occurred before age 22 and is indicated by intellectual disability, autism, cerebral palsy, epilepsy, spina bifida or other neurological impairments? ☐ Yes ☐ No

Does the Applicant need "nursing home like" services, Long Term Services and Supports, such as dressing, bathing or mobility assistance? See Brochure. ☐ Yes ☐ No

Ever applied before? ☐ Yes If yes, which county _____ ☐ No

SECTION 2 Demographic Information for the Applicant 2 (Spouse)

Date of Birth: ____ - ____ - ____ Sex: ☐ Male ☐ Female
Month Day Year

Citizenship Status: ☐ US Citizen ☐ Lawful Permanent Resident ☐ Refugee

☐ Asylee ☐ Not Lawfully Admitted ☐ Legal Immigrant _____
Date of Entry

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Date Applied _____

Case # _____

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

USCIS/Alien # _____ Immigration Card # _____
 Official Name on Immigration Document/Card (AKA) _____
 Social Security Number: _____ Medicare ID Number: _____
 Marital Status: ☐ Single ☐ Married, Date _____ ☐ Divorced, Date _____
☐ Widowed, Spouse's Date of Death _____ ☐ Separated, Date _____ ☐ Child (under age 19)

SECTION 3 Intentionally left blank

SECTION 4 Assistance with Application

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

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

Provide the following information for this person:

Name _____
 Address _____
 Street City State Zip Code
 Phone Number: (____) ____ - ____ E-mail Address: _____

SECTION 5 Health Insurance Information - Applicant 2 (Spouse)

- ☐ **Medicare Part A** Date Eligible _____
 Does the Applicant pay a premium? ☐ Yes Monthly Amount? _____ ☐ No
☐ **Medicare Part B** Date Eligible _____
 Does the Applicant pay a premium? ☐ Yes Monthly Amount? _____ ☐ No
☐ **Medicare Part C** Date Eligible _____
 Does the Applicant pay a premium? ☐ Yes Monthly Amount? _____ ☐ No
☐ **Medicare Part D** Date Eligible _____
 Does the Applicant pay a premium? ☐ Yes Monthly Amount? _____ ☐ No

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Date Applied _____
 Case # _____

SECTION 5 - HEALTH INSURANCE INFORMATION - continued

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

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

Name of Policy	Policy Number	Policy Premium

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

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

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

SECTION 6 Living Arrangements - Applicant 2 (Spouse)

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

- ☐ Home: Own ☐ Rent ☐ Living with Spouse ☐ Nursing Facility
☐ Assisted Living Facility ☐ Residential Care Facility
☐ Renting a room(s) in another person's residence ☐ Living with Relative or Friend
☐ Other: Identify Living Arrangement: _____

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

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Date Applied _____
Case # _____

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

☐ Yes ☐ No

SECTION 7 Applicant and Beneficiary 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.

- 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 New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) for the Medicaid/NJ FamilyCare program, which is called **"NJ FamilyCare"** in this application. I understand that my medical benefits may be reduced, denied, or stopped because of information received through this verification.
- I understand that my situation is subject to verification from employers, financial sources and other third parties. I hereby give permission to NJ FamilyCare to contact any individual or other source that may have knowledge about my circumstances, or the circumstances of a person necessary for this application, for the purpose of verifying the statements I have made. I give third parties permission to share information about me with authorized State, State contractor, and county staff conducting investigations. 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 necessary. I further authorize taxing authorities to release my tax information and copies of my tax returns.
- I understand that the DMAHS eligibility determining agencies and government contractors may exchange information relating to coverage to assist with this application, enrollment, administration, and billing services.

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Date Applied _____

Case # _____

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- I understand that DMAHS has the authority to file a claim and lien against the estate of a deceased Medicaid beneficiary, or former beneficiary, to recover all NJ FamilyCare payments made on the beneficiary's behalf to pay for health care coverage on or after age 55, regardless of whether services were received. A NJ FamilyCare beneficiary's estate may be required to pay back DMAHS for those benefits. This includes monthly payments to, for example, a managed care entity to secure health coverage that you may not use in any month. More information about Estate Recovery is available online at: www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf
- I agree to tell the eligibility determining agency immediately of changes to information entered on this application, including but not limited to the following:
 - 1) If anyone receiving health benefits moves out of state;
 - 2) Changes in where we live, get our mail, or any other contact information;
 - 3) Changes in other health insurance coverage;
 - 4) Changes in income and/or resources;
 - 5) Improvement in medical condition, if disabled;
 - 6) Marriage, divorce, or death of spouse;
 - 7) Addition or loss of household member, including pregnancy;
 - 8) Sale or transfer of my home or other property;
 - 9) Lawsuits and inheritances.

I understand that failure to report changes in application information, including those changes listed above, may result in incorrectly paid benefits/coverage and I may have to reimburse the State of New Jersey for those benefits/coverage.

- I understand that the outcome of this application may be shared with any provider who provided services to the applicant/beneficiary during the period covered by the application.
- I understand, as a condition of being covered under Medicaid/NJ FamilyCare, that I have assigned to the Commissioner of the Department 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 including but not limited to other health insurance, legal settlements, or other third parties. 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 agree to help in obtaining medical support and payments from anyone who is legally responsible.
- I understand that I may request a fair hearing if I am not satisfied with the determination taken regarding my application.

FOR OFFICE USE ONLY

Date Applied _____
Case # _____

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- 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 resources, depending on the program. I understand that if I am seeking Long Term Services and Supports or services based on an institutional level of care, NJ FamilyCare will examine transfers of resources that occurred within the look back period before, and any time after, my first date of applying for benefits.
- In order to redetermine my eligibility for NJ FamilyCare in the future, I agree to allow NJ FamilyCare to use income data, including tax information. At time of renewal, NJ FamilyCare will send me a renewal notice and let me indicate any changes in my or my household's eligibility information, and I can withdraw my request for benefits in writing at any time.
- I understand that if some or all of the individuals applying do not qualify for NJ FamilyCare health coverage, that they may be eligible for federal benefits and/or may explore private health coverage options through the Federal Health Insurance Marketplace (Marketplace). If this is the case, I authorize NJ FamilyCare and its contractors to give information contained in this application to the Marketplace.
- I confirm that I have read and understood the NJ FamilyCare Privacy Policy available online at: <https://njfc.force.com/familycare/NJPrivacyNotice> and the Notice of Privacy Practices available online at: www.njfamilycare.org/docs/NJFC-HIPAA.pdf
- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if State or Federal privacy laws require or allow it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support.
- I will obey the law and regulations of the program.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can get more information, including how to file a complaint of discrimination by reading the NJ FamilyCare Non-Discrimination Statement available online at: www.njfamilycare.org/docs/ndc_english.pdf

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Date Applied _____

Case # _____

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7. The SSNs provided (including for a husband or wife, family members, or dependents) will be used to associate records pertaining to applicants and other persons necessary for the determination of eligibility, to verify identity, to verify income, to check other financial records such as bank account information, to the extent it is useful in verifying eligibility or the amount of medical assistance payments under 42 CFR 435.940 through 435.960, and preventing duplicate participation or incorrectly paid benefits for you and for persons in your household. The SSNs will be used in computer matching and program reviews or audits. These procedures are designed to determine eligibility and to identify persons who fraudulently or wrongfully participate in Medicaid and DMAHS programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.

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

SECTION 8 Signature - Applicant 2 (Spouse)

The person who filled out this application must sign this application. If you're an authorized representative you may sign here, as long as you have provided the Designation of Authorized Representative Form.

By signing below, I certify under penalty of perjury and false swearing that my answers on this application are true, correct and complete to the best of my knowledge. I also certify that:

- I understand the questions and statements on this application.
- I understand that I may be subject to penalties under federal and state law if I provide false or untrue information.

By signing below I also certify that I have read and understand the Applicant and Beneficiary Rights and Responsibilities included.

Applicant 2 (Spouse's) Signature

Date (mm/dd/yyyy)

Authorized Representative Name

Relationship

Authorized Representative Signature

Date (mm/dd/yyyy)

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

FOR OFFICE USE ONLY

Date Applied _____

Case # _____

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Non-Discrimination Statement

Discrimination is Against the Law

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. NJ FamilyCare does not exclude people or treat them differently because of race, color, national origin, sex, age or disability.

NJ FamilyCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please contact 1-800-701-0710 (TTY: 1-800-701-0720).

If you believe that NJ FamilyCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age or disability, you can file a grievance with the NJ FamilyCare Civil Rights Coordinator via the following: NJ Civil Rights Coordinator, NJ Department of Human Services, Office of Legal and Regulatory Affairs, P.O. Box 700, Trenton, NJ 08625-0700, 1-888-347-5345 or email: DHS-CO.OLRA@dhs.state.nj.us. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also electronically file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
SW, Room 509F, HHH Building
200 Independence Avenue
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

U.S. Department of Health and Human Services complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

New Jersey Non-Discrimination Statement

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

Spanish. NJ FamilyCare cumple con las leyes federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, el sexo, la edad o la discapacidad. Si usted habla **español**, tiene a su disposición los servicios de asistencia con el idioma sin costo alguno. Llame al 1-800-701-0710 (TTY: 1-800-701-0720).

Chinese. NJ FamilyCare 遵守适用的联邦人权法律，不会因为种族、肤色、原国籍、性别、年龄或残障而进行歧视。如果您讲**中文**，您可以免费获得语言协助服务。致电 1-800-701-0710 (TTY: 1-800-701-0720)。

Korean. NJ FamilyCare는 적용되는 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 성별, 나이 또는 장애 여부에 따라 차별을 하지 않습니다. **한국어**를 쓰시는 경우, 언어 지원 서비스가 무료로 제공됩니다. 1-800-701-0710 (TTY: 1-800-701-0720) 번으로 문의해 주십시오.

Portuguese. O NJ FamilyCare cumpre as leis federais aplicáveis de direitos civis e não discrimina com base em raça, cor, origem nacional, sexo, idade ou deficiência. Se você fala **português**, serviços linguísticos gratuitos estão à sua disposição. Ligue para 1-800-701-0710 (TTY: 1-800-701-0720).

Gujarati. NJ FamilyCare, લાગુ પડતા ફેડરલ નાગરિક અધિકાર કાયદાઓનું પાલન કરે છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, લિંગ, વય અથવા અપંગતાને આધારે ભેદભાવ કરતું નથી. જો તમે **ગુજરાતી** બોલતા હોવ તો ભાષા સહાય સેવાઓ તમારે માટે નિ:શુલ્ક ઉપલબ્ધ છે. ફોન કરો 1-800-701-0710 (TTY: 1-800-701-0720).

Polish. NJ FamilyCare przestrzega wszelkich odnoszących przepisów federalnych dotyczących praw obywatelskich i nie dopuszcza się dyskryminacji z powodu rasy, koloru skóry, pochodzenia narodowego, płci, pochodzenia, wieku lub inwalidztwa. Dla osób mówiących po **polsku** dostępna jest bezpłatna pomoc językowa. Proszę zadzwonić pod numer 1-800-701-0710 (TTY: 1-800-701-0720).

Italian. NJ FamilyCare si attiene a tutte le leggi federali per i diritti civili e non discrimina sulla base di etnia, colore, nazionalità, genere, età o disabilità. Se lei parla **italiano**, sono a sua disposizione servizi gratuiti nella sua lingua. Chiami il numero 1-800-701-0710 (TTY: 1-800-701-0720).

Arabic. تتلزم NJ FamilyCare بتأمين الحقوق المدنية السارية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو الجنس أو السن أو الإعاقة. إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية دون تكلفة. اتصل بالرقم 1-800-701-0710 (TTY: 1-800-701-0720).

Tagalog. Ang NJ FamilyCare ay tumutupad sa mga angkop na Pederal na batas ukol sa mga sibil na karapatan at hindi ito nagdidiskrimina batay sa lahi, kulay, bansang pinanggalingan, kasarian, edad, o kapansanan. Kung nagsasalita ka ng **Tagalog**, may makukuha kang tulong sa wika nang walang bayad. Tumawag sa 1-800-701-0710 (TTY: 1-800-701-0720).

Russian. Программа NJ FamilyCare действует в соответствии с федеральным законодательством о гражданских правах и запрещает дискриминацию на основе расовой принадлежности, цвета кожи, национального происхождения, пола, возраста или инвалидности. Если вы говорите **по-русски**, то можете бесплатно получить услуги по переводу. Позвоните по номеру телефона 1-800-701-0710 (номер телефона / телетайпа для слабослышащих: 1-800-701-0720).

French Creole (Haitian Creole). NJ FamilyCare obeyi lwa federal konsenan dwa sivil yo e li pa diskrimine nonplis sou ras, koulè po, peyi natif natal, sèks, laj, ak enfimite. Si w pale **kreyòl**, gen yon sèvis tradiksyon disponib san w pa peye anyen pou li. Sonnen 1-800-701-0710 (TTY : 1-800-701-0720).

Hindi. NJ FamilyCare, लागू संघीय नागरिक अधिकार कानूनों का अनुपालन करता है और जाति, रंग, राष्ट्रीय मूल, लिंग, उम्र या विकलांगता के आधार पर भेदभाव नहीं करता है। यदि आप हिन्दी बोलते हैं तो, आपको भाषा सहायता सेवायें नि: शुल्क उपलब्ध हैं। 1-800-701-0710 (TTY: 1-800-701-0720) पर फोन करें।

Vietnamese. NJ FamilyCare tuân thủ theo luật dân quyền Liên Bang hiện hành và không kỳ thị dựa vào chủng tộc, màu da, nguồn gốc quốc gia, giới tính, tuổi hoặc khuyết tật. Nếu quý vị nói **Tiếng Việt**, hiện có các dịch vụ trợ giúp về ngôn ngữ miễn phí cho quý vị. Gọi số 1-800-701-0710 (TTY: 1-800-701-0720).

French. NJ FamilyCare respecte les lois applicables des États-Unis en matière de droits civils et ne pratique aucune discrimination fondée sur la race, la couleur, l'origine nationale, le sexe, l'âge ou un handicap. Si vous parlez le **français**, vous bénéficiez de services d'assistance linguistique gratuits. Appelez le 1-800-701-0710 (TTY : 1-800-701-0720).

Urdu. NJ FamilyCare قابل طلاق وفاقى شہرى حقوق کے قوانین کی پابندی کرتا ہے اور نسل، رنگ، قومی نژاد، جنس، عمر یا معنوری کی بنیاد پر امتیاز نہیں برتتا۔ اگر آپ اردو بولتے ہیں تو زبان سے متعلق مدد کی خدمات آپ کے لیے مفت دستیاب ہیں۔ کال کریں 1-800-701-0710 (TTY: 1-800-701-0720)۔



Notice of Privacy Practices

Effective October 1, 2016

State of New Jersey Department of Human Services

This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services. Protected health information excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act, 20 U.S.C. 1232g.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

When you apply for health coverage or services from the Department of Human Services, you provide your confidential personally identifiable information. The Department of Human Services uses this information to determine your eligibility, provide you with benefits, and run its programs. Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

OUR RESPONSIBILITIES:

The Department of Human Services is required by law to:

- Maintain the privacy and security of your health information, and notify you if a breach occurs that may have compromised the privacy and security of your information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, and abide by the terms of the notice currently in effect
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will provide you with a revised notice.

Eligibility Process Privacy Policy:

Please see our NJ FamilyCare Privacy Policy regarding the types of information we collect in the eligibility process, how we use the information we collect, how we protect that information, how long we keep it and other related privacy information. This Policy is provided as part of the NJ FamilyCare application and is found at <https://njfc.force.com/familycare/NJPrivacyNotice>.

GENERAL PRIVACY RULE

We will not use or disclose your health information without your written authorization, except as described in this notice.

Revoking Your Authorization: If you provide us with a written authorization to release your health information, you may revoke that authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

Separate Authorization for Psychotherapy Notes:

We will not release any psychotherapy notes about you without a separate written authorization from you. You may revoke your

specific written authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

- 1. Treatment.** We may use your health information for your treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information with other health care professionals who are either part of the Department of Human Services or who are outside the Department of Human Services to determine how to diagnose or treat you.
- 2. Payment.** We may use your health information for payment. For example, payments made by the Department to providers for the care they provided to you will identify you and list a description of the care being paid for, including your diagnosis, procedures and supplies used.
- 3. Health Care Operations.** We may use your health information for regular health operations. For example, members of the medical staff or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.
- 4. Business Associates.** There are some services provided in our organization through contracts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require that the business associates safeguard your information.
- 5. Facility Directory.** If you do not object, we may include your name, location and general condition in a Department facility directory while you are at the facility. This information would only be disclosed to people who ask for you by name. In addition, unless you object, we may include your religious affiliation to disclose only to clergy members at the facility and will disclose that information even if the clergy member does not ask for you by name.
- 6. Family and Friends Involved in Your Care.** If you do not object, we may share your health information with a family member, a relative or close personal friend who is involved in your care or payment related to your care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us to notify those persons.
- 7. Research.** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- 8. Funeral Directors.** We may disclose health information to funeral directors, coroners or medical examiners to carry out their duties consistent with applicable law.

9. Organ, Eye or Tissue Procurement Organizations.

Consistent with applicable law, we may disclose health information to organ, eye or tissue procurement organizations or other entities engaged in the procurement, banking of organs, or transplantation of organs, or for the purpose of eye or tissue donation and transplant.

10. Contacts. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

11. Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food supplements, products and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

12. Workers Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

13. Public Health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also disclose your information to avert a serious threat to health or safety.

14. Correctional Institution. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

15. Law Enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

16. Abuse, Neglect or Domestic Violence. We may disclose your health information to the extent provided by law to an authority, social service agency or protective services agency if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will notify you of this disclosure promptly unless it would place you at risk of serious harm.

17. Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law such as audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for oversight of the health care system, government benefit programs, government regulated programs, or compliance with civil rights laws.

18. Judicial and Administrative Proceedings. We may disclose your health information in response to an order of a court or administrative tribunal, or in response to a valid subpoena if we receive satisfactory assurances from the party seeking the information that the party has made an attempt to notify you or to secure a protective order for your information.

19. National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for national security or military activities.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the following rights:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Department's general health care operations, and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing to the privacy officer. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it. If you pay for a health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.
- You have the right to receive confidential communications of your health information. If you are dissatisfied with the manner in which or location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing, and submitted to the privacy officer. We will accommodate all reasonable requests.
- You may request to inspect and/or obtain copies of health information we have about you, which will be provided to you usually within 30 days. Such requests must be made in writing to the privacy officer. If you request to receive a copy, you may be charged a reasonable fee.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. You must provide a reason to support your request. We will verify information provided before making any change. Such requests must be made in writing to the privacy officer. We may say "no" to this request and tell you why.
- You may request that we provide you with a written accounting of all disclosures made by us of your health information for up to a six-year period of time including who we shared it with and why. We ask that such requests be made in writing to the privacy officer. Please note that an accounting will not include the following types of disclosures: disclosures made for treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures authorized by you or your legal representative; disclosures to correctional institutions or law enforcement officials or for national security purposes; disclosures made from the directory; and disclosures that are incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by). There is no charge for the first request for an accounting made in any 12 month period, but there may be a reasonable charge for additional requests in the same 12 month period.
- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.
- You may revoke any authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing to the privacy officer.

Requests related to your privacy rights may be sent to the Division of Medical Assistance and Health Services (DMAHS) Privacy Officer at: P.O. Box 712, Trenton, NJ 08625-0712, (609) 588-2102.

****Please Note: YOUR BENEFITS OR ELIGIBILITY WILL NOT BE AFFECTED BY THIS NOTICE.****

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the appropriate privacy officer listed below.

If you believe that your privacy rights have been violated, you may file a complaint with us. Complaints must be filed in writing to the Department's Privacy Officer at State of New Jersey, Department of Human Services, PO Box 700, Trenton, NJ 08625 or with DMAHS's Privacy Officer at P.O. Box 712, Trenton, NJ 08625-0712 (609-588-2102).

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights by writing to 200 Independence Avenue SW, Washington, DC 20201. This needs to be done within 180 days of when the problem happened. You can also complain to the Office of Civil Rights by calling 877-696-6775, or by filing on-line at www.hhs.gov/hipaa/filing-a-complaint/index.html.

If you make a complaint to the Department's Privacy Officer or to the Secretary of Health and Human Services, there will be no retaliation against you and your benefits will not be affected.

DEPARTMENT OF HUMAN SERVICES PRIVACY OFFICERS

Department of Human Services

222 So. Warren Street
P.O. Box 700
Trenton, NJ 08625
(888) 347-5345

Division of Medical Assistance and Health Services (DMAHS)

P.O. Box 712, Trenton, NJ 08625-0712

Division of Aging Services (DoAS)

P.O. Box 715, Trenton, NJ 08625-0715

DMAHS and DoAS Privacy Complaints

can be made to:

- **609-588-2102** or
- MAHS.Privacy@dhs.state.nj.us
(do not include confidential or personally identifiable information in an email to this email address) or
- in writing to the above addresses.



Voter Registration Opportunity

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

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

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

You can register to vote if:

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

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

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

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

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

☐ Yes

☐ No

☐ I am already registered

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

Print Name

Signature

Date

For Official Use

RTS ☐

____ Initial



New Jersey Voter Registration Application

33

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

1 Check boxes that apply: ☐ New Registration ☐ Address Change ☐ Political Party Affiliation ☐ Name Change ☐ Signature Update or Non-affiliation Change						FOR OFFICIAL USE ONLY Clerk _____ Registration # _____ Office Time Stamp _____	
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)		☐ by mail ☐ in person
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."							
6 Home Address (DO NOT use PO Box)		Apt.	Municipality	County	State	Zip Code	
7 Mailing Address if different from above		Apt.	Municipality	County	State	Zip Code	
8 Last Address Registered to Vote (DO NOT use PO Box)		Apt.	Municipality	County	State	Zip Code	
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? ☐ Yes, the party name is _____. (Optional) ☐ 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 | ☐ polling place accessibility | ☐ available election materials in this alternative language: |
| ☐ becoming a poll worker | ☐ voting if you have a disability, including visual impairment | |

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.

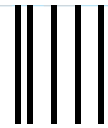
**You may register to vote if you are at least 17 years old but cannot vote until reaching the age of 18.*

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

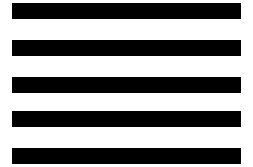


NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

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

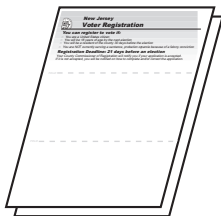
POSTAGE WILL BE PAID BY ADDRESSEE

DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

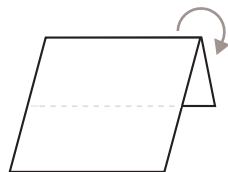


2 FOLD

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



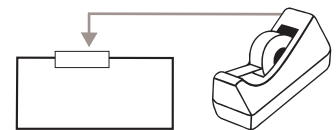
Put both pages
together as shown



1 fold top down



2 fold bottom up



3 Tape top shut

TAPE HERE **3**