State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner

JOHN R. GUHL
Director

MEDICAID COMMUNICATION NO: 07-14 **DATE:** August 8, 2007

TO: **County Welfare Agency Directors**
NJ FamilyCare Liaisons

SUBJECT: **New Combined Application for Both Presumptive Eligibility (PE) for Pregnant Women and New Jersey Care**

In an effort to improve the healthcare delivery process for pregnant women, a new PE application is now available. The PE for Children application has been revised to include PE for Pregnant Women (copy attached). Beginning September 1, 2007, this is the only application that will be used for determining PE. Therefore, providers will no longer be able to use the 4-part form FD-334; nor will staff need to complete the "New Jersey Care Pregnant Women and Infants" form FD-335 to determine full Medicaid/NJ FamilyCare eligibility. At this time, an online application is not available for PE for Pregnant Women.

This application will be processed by the County using the regular NJ FamilyCare application instructions and documentation requirements. A face-to-face interview is not required.

After staff establishes eligibility and records the policy number in the lower right-hand corner, the staff person must make a copy for the Health Benefit Coordinator (HBC) according to the process outlined in Medicaid Communication No: 07-11, dated April 4, 2007 (copy attached). The HBC must receive a copy of this application in order to promptly enroll the pregnant woman into an HMO.

Questions concerning this communication should be referred to the Division of Medical Assistance and Health Services field staff assigned to your county.

Sincerely,

John R. Guhl
Director

JRG:lg
Attachments

C: Jennifer Velez, Commissioner
Department of Human Services

William Ditto, Executive Director
Division of Disability Services

Greg Fenton, Acting Director
Division of Developmental Disabilities

Kevin Martone, Assistant Commissioner
Division of Mental Health Services

Jeanette Page-Hawkins, Director
Division of Family Development

Eileen Crummy, Director
Division of Youth and Family Services
Department of Children and Families

Fred M. Jacobs, M.D., J.D., Commissioner
Kathleen M. Mason, Assistant Commissioner
Department of Health and Senior Services

FAMILYCARE
Affordable health coverage. Quality care.

PE Pregnant Woman
County ____________

PE Children
❑ County ____________ ❑ Vendor

NJ FamilyCare
P.O. Box 8367, Trenton, NJ 08650
1-800-701-0710 (TTY 1-800-701-0720)

1. Household Information

Home Address:	Apt. #/Floor:	Home Phone:	Cell Phone:	Other Phone:
City:	County:	State: Zip:	Language spoken at home:	
Mailing Address, if different:		City:	State:	Zip:

List ALL Parents/Guardians and Children UNDER THE AGE OF 21 Living in Your Household

Parent/Guardian First Name	Last Name	Do you want NJ FamilyCare?	Sex M/F	Social Security Number (Required for those applying)	Race/Ethnicity (only for those applying)*	Birth Date MM/DD/YYYY	US Citizen? (If NO, fill in date of entry)**	Full-time Student?	Other health insurance now?***	Other health insurance within the past 3 months?	Parent/Guardian Marital Status: Single	Married	Separated	Divorced	Widow/er
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑	❑	❑	❑	❑
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑	❑	❑	❑	❑

Are your children currently enrolled in NJ FamilyCare? ❑Yes ❑No

*Race/Ethnicity Codes: B-Black S-Hispanic W-White O-Other I-Native American Indian/Alaska Native A-Asian/Pacific Islander

**Name/Date of Entry ____________

***Insurance Company ____________
Ins Co Policy # ____________

Children First Name	Last Name	Do you want NJ FamilyCare?	Sex M/F	Social Security Number	Race/Ethnicity	Birth Date	US Citizen?	Full-time Student?	Other health insurance now?	Other health insurance within the past 3 months?	How is this child related to the 1st parent/guardian listed above?	How is this child related to the 2nd parent/guardian listed above?
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other
		❑Yes ❑No		- -		/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other

More Children?
Use another piece of paper.

► Is anyone listed above pregnant? ❑Yes ❑No
If yes, write name(s) and due date(s): ____________

► Does anyone have unpaid medical bills for the last 3 months? Yes❑ No❑
If yes, please write name(s): ____________

2. Income Information for Parents/Guardians and Children under 21:

Name of person receiving income, including children	Employer Name ■ If self-employed write "self-employed", or ■ If owner, write "owner"	Employer telephone number	Date job started	Full-time or Part-time? FT	PT	How often paid? Every Week	Every 2 Weeks	2 Times a Month	Once a Month	Work income before taxes per pay period: Amount	Other income such as child support, alimony, cash support, social security benefits, unemployment, rental income, etc: Indicate Type of Income	Monthly Amount	If this person PAYS for day care for a child or disabled adult, list monthly amount	If this person PAYS child support or alimony, list monthly amount
				❑	❑	❑	❑	❑	❑	$		$	$	$
				❑	❑	❑	❑	❑	❑	$		$	$	$
				❑	❑	❑	❑	❑	❑	$		$	$	$

► Do any of the employers listed above offer health insurance? Yes❑ No❑ If yes, please list the Employer Name: ____________ Employer address: ____________

► Has anyone listed changed jobs in the last six months? Yes❑ No❑ If yes, please list Name ____________ Former employer: ____________ Date job ended: ____________

3. HMO SELECTION: You must pick an HMO to be enrolled. Please see HMO flyer for available HMOs.

Choose an HMO: ____________ Who is your doctor? ____________ Address: ____________

Who is your child's doctor? ____________ Address: ____________

Is anyone listed above: Taking prescription medicines? Yes ❑ No ❑ Receiving any medical treatment? Yes ❑ No ❑ Using any special medical equipment? Yes ❑ No ❑

By signing this form, I represent that I have read and understood the Privacy Notice and the NJ FamilyCare program "Rights and Responsibilities", and that I will obey the law and regulations of the program. I understand that I am giving the NJ FamilyCare program permission to release my medical records and those of any of my family members who enroll in the program, to the program's HMOs and its providers. I also authorize the NJ Division of Taxation to release my tax return information to the NJ FamilyCare program. In addition, I hereby authorize any educational institutions or school district to release my medical records or those of my child(ren) to the NJ Famil…re program for the purpose of determining eligibility and billing the Program. I ce… under penalty of law that everything on this application is true.

… your name here: ____________ ____________ Date: ____________

Jon S. Corzine
Governor, State of New Jersey

PE Provider #: ____________

Provider Signature ____________

Policy Number ____________

NJ FamilyCare does not discriminate against anyone b…se of race, age, color, religion, sex, na… …igin, marital status, disability or polit… …ef.

NJFC-APP-PE-0707

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JON S. CORZINE
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JENNIFER VELEZ
Acting Commissioner

JOHN R. GUHL
Director

MEDICAID COMMUNICATION NO: 07-11 DATE : April 4, 2007

TO: County Welfare Agency Directors
NJ FamilyCare Liaisons

SUBJECT: New Procedure for Processing the Client's HMO Selection from the One-Page Application

In an effort to decrease the number of clients who are auto-assigned to HMOs, the Division is requesting your cooperation in implementing a new procedure.

Currently the one-page NJ FamilyCare application, which is used to determine eligibility and to select an HMO, is being sent to ACS **before** eligibility has been established by the County Board of Social Services and in some cases the application is not sent at all. Because ACS cannot process the HMO selection form until eligibility has been established, many clients are being auto-assigned after they have selected an HMO on the one-page application.

Additionally when clients are outreached by ACS to select an HMO, they often do not respond because they have already selected an HMO on their application. To help remedy this issue, please follow these instructions which have been discussed at the NJ FamilyCare supervisors meeting.

Once eligibility has been established:

1. The 12-digit case # (Policy #) must be written in the box in the lower right hand corner of the application.

2. The words "HMO only" should be written on the top of the application.

3. The HMO choice, the Policy #, and the signature should be visible on the copy submitted to ACS in order for ACS to facilitate enrollment.

4. Application copies should be put in bins provided by ACS after the case is on OIT or has supervisor sign off.

5. Do not mail application copies directly to ACS.

6. ACS staff will pick up applications routinely from the bins. They will review and reconcile with the CBOSS supervisor any application placed in the bin without a policy number.

Electronic applications should be treated in the same way as the mailed-in applications. Be sure a copy of the electronic application with the policy number is placed in the ACS bin.

Questions concerning this communication should be referred to the field staff assigned to your county.

Sincerely,

John R. Guhl
Director

JRG:hs

c: Jennifer Velez, Acting Commissioner
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