New Jersey Department of Health
AIDS Drug Distribution Program (ADDP) and
Health Insurance Continuation Program (HICP)
PO Box 722
Trenton, NJ 08625-0722

CERTIFICATION OF SEPARATION

Date of Initial Separation: ______________________________

Name of Applicant: ______________________________

Legal Residence of Applicant:

Street Address: ______________________________

City, State, Zip Code: ______________________________

Name of Spouse: ______________________________

Legal Residence of Spouse:

Street Address: ______________________________

City, State, Zip Code: ______________________________

I, ______________________________, certify and attest to the truthfulness
(Print Name of Applicant)

of the following:

1. That my spouse and I are separated and no longer reside together.
2. That I have no access to the funds of my spouse.
3. That I receive no support or monies from my spouse.
4. That my spouse and I do not mingle or join our funds in any way <u>including the filing of joint federal or state income tax returns</u>.

I certify that the foregoing statements made by me are true.

Signature of Applicant	Date