**N.J. Department of Human Services**
**Division of Developmental Disabilities (DDD)**

# Application for DDD Eligibility
# APPLICANT INFORMATION FORM

**Please provide as much information as possible. Attach additional sheets as necessary.**

Applicant Name_____ Form Completed by_____

Date of Birth _____ Relationship to Applicant_____

Social Security # _____ Date completed_____

Applicant's Primary Address:_____

_____

Phone: _____ E-mail_____

Does Applicant have a Legal Guardian? ____ Yes _____No If yes, please complete:

Name: _____ Phone #:_____

Address: _____

## 1. APPLICANT RESIDENCY AND OCCUPATION INFORMATION

Place of Birth (hospital, city, state or country if born outside U.S.):

_____

_____

If born outside U.S., is Applicant a U.S. citizen? ____ Yes ____ No

If No, is Applicant a permanent alien resident? _____Yes _____No

If Applicant is under 18, are parents/legal guardian permanent legal residents of New Jersey?

_____ Yes _____ No

If Applicant is 18 or older and has a legal guardian, is the legal guardian a permanent legal resident of New Jersey? _____Yes _____ No _____ Has no legal guardian

Is Applicant currently receiving services from any agency in any state other than New Jersey?

_____Yes _____ No If yes:

| Name of Agency | Address | Phone # |
|---|---|---|
| _____ | _____ | _____ |

Does Applicant Reside in a Residential Program? _____Yes _____ No If yes, please complete:

Placement Type: _____

Provider Name: _____

Is Applicant Employed? _____ Yes _____ No If yes, please complete:

Employer Name: _____

Position: _____

Does Applicant Attend a Day Program or School? _____Yes _____No If yes, please complete:

Type of Program: _____ Phone # _____

Name of Program/School: _____

Address: _____

## 2. APPLICANT INSURANCE AND BENEFIT INFORMATION

Does Applicant have or receive:

- Medicaid? _____Yes _____No If yes, Medicaid Number_____
  **(Note: This is not the number on your Medicaid card. If necessary, call N.J. Medicaid at 800-356-1561 and ask for it.)**
- Medicare? _____Yes _____No If yes, Medicare Number _____
- Private Insurance? _____Yes _____No If yes, please list: Policy Name:_____

  Policy Number: _____ Telephone Number:_____
- Social Security Administration Death or Disability (SSA/SSDI) benefits? _____Yes ____ No
- If yes: Claim # _____ and amount received per month: $ _____
- If no: _____ Never applied _____ Application pending _____Ineligible
- Supplemental Security Income (SSI) benefits? _____Yes _____No
- If yes: Claim # _____ and amount received per month $ _____
- If no: _____Never applied _____ Application pending _____Ineligible
- If Applicant receives SSA/SSDI or SSI, is there a Representative Payee? _____Yes _____No
- If yes, please complete:

| Benefit | Name | Address | Phone | Relationship |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Is Applicant requesting an immediate residential placement funded by DDD? ____ Yes _____No**

- **If no, please move to Section 3.**
- **If yes and Applicant is 18 or older, please complete Section 2a but NOT 2b.**
- **If Applicant is under 18, please complete both sections 2a AND 2b.**

**2a. For all Applicants requesting a DDD-funded residential placement:**

OTHER BENEFITS AND ASSETS OWNED OR RECEIVED BY APPLICANT Include Salary, Bank Accounts, Trust Accounts, Stocks & Bonds, Malpractice Accounts, Pensions, Alimony, Veteran's Benefits, Railroad Retirement Benefits, etc. Attach separate sheet if necessary.

| Account/Benefit Name | Address | City/State/Zip | Account/Claim # | Balance or Amt. Rec.Mthly. |
|---|---|---|---|---|
| | | | | |
| | | | | |

Representative Payee: Who is Representative Payee for these benefits or assets? Please list below:

| Benefit Or asset | Name | Address | City/State/Zip | Phone | Relationship |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**2b. *For Applicants under 18 requesting a DDD-funded residential placement:***

BENEFITS AND ASSETS OWNED OR RECEIVED BY PARENTS Please show all assets or sources of income personally owned by or received by Parents of Applicant, such as Parents' Salaries, Bank Accounts, Trust Accounts, Stocks & Bonds, Malpractice Accounts, Veteran's Benefits, Railroad Retirement Income, Pensions, etc.

**Father**

| Account/Benefit Or Employer Name | Address | City/State/Zip | Account/Claim # | Balance or Amt. Rec.Mthly. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Mother**

| Account/Benefit Or Employer Name | Address | City/State/Zip | Account/Claim # | Balance or Amt. Rec.Mthly. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**3. APPLICANT FAMILY AND HOUSEHOLD INFORMATION**

**Father:** _____Living _____Deceased If living, please complete the following:

Name_____ Date of Birth: _____

Address, if different from Applicant:_____

Phone: (Home) _____ (Work)_____ (Cell) _____

E-mail: _____

Social Security #:_____Veteran? _____Yes _____No

Marital Status _____ Is Father an Emergency Contact? _____Yes _____No

**Mother:** _____ Living _____Deceased If living, please complete the following:

Name_____ Date of Birth: _____

Address, if different from Applicant:_____

Phone: (Home) _____ (Work)_____ (Cell) _____

E-mail: _____

Social Security #: _____ Veteran? ___Yes ___No___ Marital Status _____

Marital Status/Maiden Name: _____ Is Mother an Emergency Contact? ____Yes ___ No

**Other Members of Applicants Household (Do not include parents if they are listed above)**

Name _____ DOB _____ Relationship _____

Name_____DOB_____Relationship _____

Name _____ DOB_____ Relationship _____

**Is a Family Member Applying or Currently Eligible for DDD Services?**

Name _____DOB _____ Relationship_____ Resides in the Home? ☐

Name _____DOB _____ Relationship_____ Resides in the Home? ☐

Name _____DOB _____ Relationship_____ Resides in the Home? ☐

**Immediate Family Members Who Do Not Reside with Applicant (Do not include parents if listed above)**

Name _____ DOB _____Relationship_____

Address:_____ Phone #:_____

Name _____ DOB _____Relationship_____

Address:_____ Phone #:_____

**4 . EMERGENCY CONTACT INFORMATION** ***if different from, or in addition to, parents or guardian***

Name _____Phone #_____ Relationship_____

Name _____ Phone # _____ Relationship _____