NJFAMILYCARE
Affordable health coverage. Quality care.

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

SECTION 2 Demographic Information for the Applicant

Date of Birth: ___ ___ – ___ ___ – ___ ___ ___ ___ Sex: ❑ Male ❑ Female
Month Day Year

Citizenship Status:

❑ US citizen or US national ❑ Naturalized or derived citizen (born outside of the US)
If naturalized or derived citizen, enter
USCIS #_____ and Certificate #_____
Certificate Type: ❑ Naturalization Certificate ❑ Certificate of Citizenship

FOR OFFICE USE ONLY

HMO choice _____

Date Applied _____

Case # _____

NJFC-ABD-APAUSP-1222

SECTION 2 - DEMOGRAPHIC INFORMATION FOR THE APPLICANT - continued

If not a citizen, does the Applicant have an eligible immigration status?
Examples of eligible immigration status are:

- Child under age 21 or pregnant woman: Lawfully residing in the US
- Adult: Lawful Permanent Resident for 5 years OR qualified non-citizen, such as refugee or asylee

❑ Yes, enter information below: ❑ No

Immigration document type_____ Status type (optional)_____

Applicant's name as it appears on immigration document_____

USCIS or I-94 number_____ Card or Passport Number_____

SEVIS ID or expiration date (optional) _____

Other (category code or country of origin) _____

Has the Applicant lived in the US since 1996? ❑ Yes ❑ No

Is the Applicant, or Applicant's spouse or parent, a veteran or an active-duty member of the US military? ❑ Yes ❑ No

Social Security Number (SSN): ___ ___ ___ – ___ ___ –___ ___ ___ ___

If no SSN, has the Applicant applied for one?
❑ Yes ❑ No Enter reason: ❑ Not needed for work ❑ Religious reasons ❑ Not eligible

If you have an SSN, providing your SSN and the SSN of other household members can speed up the application process. We use SSNs to check income and other information to see who in your household qualifies for health coverage. If someone wants help getting an SSN, call 1-800-772-1213 (TTY: 1-800-325-0778) or visit socialsecurity.gov. If you do not have an SSN, we will use other documents to process your application.

Medicare ID Number: _____

Marital Status: ❑ Single ❑ Married, Date _____ ❑ Divorced, Date _____

❑ Widowed, Spouse's Date of Death _____ ❑ Child (under age 19) ❑ Separated, Date _____

Your answers to questions about race and ethnicity can help us serve the community better. They will not affect if you qualify for coverage or what services you can receive.

Race (Check all that apply.) ❑ Prefer not to answer

❑ White
❑ American Indian or Alaska Native
❑ Black or African American
❑ Other:_____
❑ Asian Indian
❑ Chinese
❑ Filipino
❑ Japanese
❑ Korean
❑ Vietnamese
❑ Other Asian: _____
❑ Guamanian or Chamorro
❑ Native Hawaiian
❑ Samoan
❑ Other Pacific Islander: _____

Ethnicity (Check all that apply) ❑ Prefer not to answer

❑ Mexican, Mexican American, Chicano/a
❑ Puerto Rican
❑ Cuban
❑ Another Hispanic, Latino/a, or Spanish origin
❑ Not of Hispanic, Latino/a, or Spanish origin

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: _____

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).

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, date of birth, 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 _____

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) **$** _____

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? $_____

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) **$** _____

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 _____

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 _____

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 _____

TRUSTS

Testamentory 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 _____

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

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: 711.

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)
- ❑ **UnitedHealthcare Community Plan** (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.

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 that 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 (DHS), 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 DHS, including its operating Divisions, eligibility determining agencies, government contractors, and other appropriate State of New Jersey agencies, 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. An 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 care 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

SECTION 12 - 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 New Jersey;
    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 a spouse;
    7) Addition or loss of household member, including pregnancy;
    8) Sale or transfer of my home or other property; or,
    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 a 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 of 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 a certain amount in resources, depending on the program's eligibility requirements. 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 5 year look-back period before,

SECTION 12 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

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 care coverage, that they may be eligible for federal benefits and/or may explore private health care coverage options through the State of New Jersey's Health Insurance Marketplace (Marketplace) at GetCovered.NJ.gov.

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 NJ FamilyCare 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 NJ FamilyCare.
- I know that under federal law, discrimination is not 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, and 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 to prevent 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 DHS 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: 711).

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.

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 3801 ROUTE 9 SOUTH UNIT 4 RIO GRANDE, NJ 08242 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 WELFARE 321 UNIVERSITY AVENUE, 2ND FLOOR 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

NJFAMILYCARE
Affordable health coverage. Quality care.

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

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

NJFC-ABD-APAUSP-1222

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

NJFAMILYCARE
Affordable health coverage. Quality care.

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

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/yyy)

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 or US national ❑ Naturalized or derived citizen (born outside of the US)

If naturalized or derived citizen, enter
USCIS #_____ and Certificate # _____

Certificate Type: ❑ Naturalization Certificate ❑ Certificate of Citizenship

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

If not a citizen, does the Applicant have an eligible immigration status?
Examples of eligible immigration status are:

- Child under age 21 or pregnant woman: Lawfully residing in the US
- Adult: Lawful Permanent Resident for 5 years OR qualified non-citizen, such as refugee or asylee

❑ Yes, enter information below: ❑ No

Immigration document type_____ Status type (optional)_____

The Applicant's name as it appears on immigration document_____

USCIS or I-94 number_____ Card or Passport Number_____

SEVIS ID or expiration date (optional) _____

Other (category code or country of origin) _____

Has the Applicant lived in the US since 1996? ❑ Yes ❑ No

Is the Applicant, or the Applicant's spouse or parent, a veteran or an active-duty member of the US military? ❑ Yes ❑ No

Social Security Number (SSN) ___ ___ ___ – ___ ___ –___ ___ ___ ___

If no SSN, has the Applicant applied for one?

❑ Yes ❑ No enter reason: ❑ Not needed for work ❑ Religious reasons ❑ Not eligible

If you have an SSN, providing your SSN and the SSN of other household members can speed up the application process. We use SSNs to check income and other information to see who in your household qualifies for health coverage. If someone wants help getting an SSN, call 1-800-772-1213 (TTY: 1-800-325-0778) or visit socialsecurity.gov. If you do not have an SSN, we will use other documents to process your application.

Medicare ID Number: _____

Marital Status: ❑ Single ❑ Married, Date _____ ❑ Divorced, Date _____

❑ Widowed, Spouse's Date of Death _____ ❑ Child (under age 19) ❑ Separated, Date _____

Your answers to questions about race and ethnicity can help us serve the community better. They will not affect if you qualify for coverage or what services you can receive.

Race (Check all that apply). ❑ Prefer not to answer

❑ White
❑ American Indian or Alaska Native
❑ Black or African American
❑ Other:_____
❑ Asian Indian
❑ Chinese
❑ Filipino
❑ Japanese
❑ Korean
❑ Vietnamese
❑ Other Asian: _____
❑ Guamanian or Chamorro
❑ Native Hawaiian
❑ Samoan
❑ Other Pacific Islander: _____

Ethnicity (Check all that apply) ❑ Prefer not to answer

❑ Mexican, Mexican American, Chicano/a
❑ Puerto Rican
❑ Cuban
❑ Another Hispanic, Latino/a, or Spanish origin
❑ Not of Hispanic, Latino/a, or Spanish origin

SECTION 3 Intentionally left blank

NJFC-ABD-APAUSP-1222

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

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, date of birth, and relationship

_____

_____

_____

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 that 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 (DHS), 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.

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- 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 DHS, including its operating Divisions, eligibility determining agencies, government contractors, and other appropriate State of New Jersey agencies, 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. An 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 care 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 New Jersey;
    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 a spouse;
    7) Addition or loss of household member, including pregnancy;
    8) Sale or transfer of my home or other property; or,
    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.

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- 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 a 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 of 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 a certain amount in resources, depending on the program's eligibility requirements. 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 5 year 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 care coverage, that they may be eligible for federal benefits and/or may explore private health care coverage options through the State of New Jersey's Health Insurance Marketplace (Marketplace) at GetCovered.NJ.gov.

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 NJ FamilyCare 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 NJ FamilyCare.

SECTION 7 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- I know that under federal law, discrimination is not 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, and 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 to prevent 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 DHS 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: 711).

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.

NJFC-ABD-APAUSP-1222

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State of New Jersey
Department of State
Division of Elections

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

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New Jersey
Voter Registration Application

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

1 Check boxes that apply: ☐ New Registration ☐ Address Change ☐ Political Party Affiliation ☐ Name Change ☐ Signature Update or Non-affiliation Change

FOR OFFICIAL USE ONLY

Clerk

Registration #

Office Time Stamp

☐ by mail
☐ in person

2 Are you a U.S. Citizen? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

Are you at least 17 years of age? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

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

4 Date of Birth

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

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

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

☐ "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."

		Apt.	Municipality	County	State	Zip Code
6	Home Address *(DO NOT use PO Box)*					
7	Mailing Address if different from above					
8	Last Address Registered to Vote *(DO NOT use PO Box)*					

9 Former Name if Making Name Change

a. Day Phone Number *(Optional)* _____

b. E-Mail Address *(Optional)* _____

10 Do you wish to declare a political party affiliation? *(Optional)*
☐ Yes, the party name is _____.
☐ No, I do not wish to be affiliated with any political party.

11 Gender
☐ Female
☐ Male

Declaration - I swear or affirm that:
- I am a U.S. Citizen
- I live at the above address
- I am at least 17 years old, and understand that I may not vote until reaching the age of 18.
- I will have resided in the State and county at least 30 days before the next election
- I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws
- I understand that any false or fraudulent registration may subject me to a fine of up to $15,000, imprisonment up to 5 years, or both pursuant to R.S. 19:34-1

Signature: Sign or mark and date on lines below

x _____ Date _____

If applicant is unable to complete this form, print the name and address of individual who completed this form.

Name _____

Date _____

Address _____

Important Instructions for sections 5, 6 and 10

5) Registrants who are submitting this form by mail and are registering to vote for the first time: If you do not have any of the information required by section 5, or the information you provide cannot be verified, you will be asked to provide a COPY of a current and valid photo ID, or a document with your name and current address on it to avoid having to provide identification at the polling place.

Note: *ID Numbers are Confidential and will not be released by any governmental agency. Any person who uses such numbers illegally shall be subject to criminal penalties.*

6) If you are homeless, you may complete section 6 by providing a contact point or the location where you spend most of your time.

10) You may declare a political party affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. If you are a previously affiliated voter who wants to change political party affiliation or become unaffiliated, you must file this form no later than 55 days before the primary election in order to vote in the primary election. Completing section 10 is OPTIONAL and will not affect the acceptance of your voter registration application.

Need More Information? Check boxes below if you would like to receive more information about:

☐ voting by mail
☐ becoming a poll worker
☐ polling place accessibility
☐ voting if you have a disability, including visual impairment
☐ available election materials in this alternative language: _____

For further information visit **Elections.NJ.gov** or call toll-free **1-877-NJVOTER** (1-877-658-6837)

New Jersey
Voter Registration Information

You can register to vote if:

- You are a United States citizen.
- You are at least 17 years of age.*
- You will be a resident of the State and county 30 days before the election.
- You are **NOT** currently serving a sentence, probation or parole because of a felony conviction.

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

Registration Deadline: 21 days before an election

Your County Commissioner of Registration will notify you if your application is accepted.
If it is not accepted, you will be notified on how to complete and/or correct the application.

Questions? visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)

1 FOLD

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

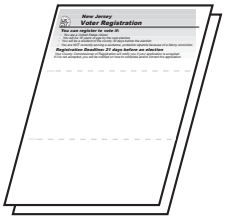
BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 206 TRENTON, NJ

POSTAGE WILL BE PAID BY ADDRESSEE

DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

2 FOLD

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



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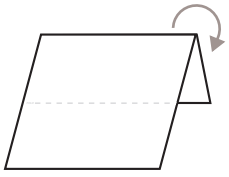

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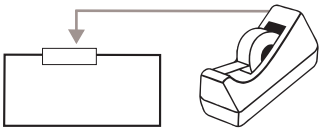

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