

SUPPLEMENTAL INFORMATION

Spouse Information Form

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 here 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

Applicant in need of Long Term Services and Support (see Brochure) Yes No

Have you ever applied for Long Term Services and Support before?
 Yes If yes, which county _____ No

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

SECTION 2 Demographic Information for the Applicant 2 (Spouse)

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

Citizenship Status: US Citizen Refugee Asylee Legal Alien _____
 Not Lawfully Admitted Date of Entry

Place of Birth: City _____ State _____ Country _____

FOR OFFICE USE ONLY	
Date Applied	_____
Registration #	_____

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

Social Security Number: _____ - _____ - _____ Medicare ID Number: _____
 Marital Status: Single Married, Date _____ Divorced, Date _____
 Widowed 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 How Much? _____ No
- Medicare Part B** Date Eligible _____
 Does the Applicant pay a premium? Yes How Much? _____ No
- Medicare Part C** Date Eligible _____
 Does the Applicant pay a premium? Yes How Much? _____ No
- Medicare Part D** Date Eligible _____
 Does the Applicant pay a premium? Yes How Much? _____ No

FOR OFFICE USE ONLY	
Date Applied	_____
Registration #	_____

NJC-ABD-SP-0217

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

FOR OFFICE USE ONLY
Date Applied _____
Registration # _____

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

- Yes No

SECTION 7 **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.

- The information I gave on this form is true to the best of my knowledge. I realize that if I knowingly give false information OR if I knowingly withhold information and I get health benefits for which I am not eligible, I can be criminally punished for fraud and I may have to pay Medicaid for any medical bills which are paid incorrectly.
- 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 NJ Department of Human Services (DHS). I understand that my medical benefits may be reduced, denied, or stopped because of information received.
- I hereby give permission to DHS to contact any individual or other source who may have knowledge about my circumstances or the circumstances of a person necessary for this application (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, financial institutions and/or credit reporting services), for the sole purpose of verifying the statements I have made.

Estate Recovery

- I understand that Medicaid payments for services received on or after age 55 may be reimbursable to the State of New Jersey from the estate of an individual who received Medicaid benefits. I also understand that this reimbursement may include, but not be limited to, capitation payments made to a managed care organization (MCO) or transportation broker for health coverage, regardless of whether the beneficiary receives services from an individual provider or entity that is reimbursed by the MCO or transportation broker. For more information about Estate Recovery, visit http://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf

FOR OFFICE USE ONLY

Date Applied _____

Registration # _____

SECTION 7 - RIGHTS AND RESPONSIBILITIES - continued

- I agree to tell the Eligibility Determining Agency immediately of the following changes:
 - 1) If anyone receiving health benefits moves out of state;
 - 2) Changes in where we live or get our mail;
 - 3) Changes in other health insurance coverage;
 - 4) Changes in income and/or resources;
 - 5) Improvement in medical condition, if disabled;
 - 6) Marriages and/or divorces;
 - 7) Family members moving in or out of my household;
 - 8) Sale of my home or other property;
 - 9) Student status.

I understand that failure to do so may result in incorrectly paid benefits and I may have to reimburse the State of New Jersey for those benefits.

- I understand that the outcome of this application may be shared with any provider providing services or who provided services to the applicant/beneficiary.
- I understand, as a condition of eligibility for medical assistance, that I have assigned to the Commissioner 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.
- I understand that I may request a fair hearing if I am not satisfied with any action 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 applicable program resources in order to be eligible. I understand that if I am seeking Long Term Services and Supports, NJ FamilyCare will examine transfers of resources that occurred within the look back period before, and anytime after, my first date of applying for benefits.
- I give third parties permission to share information about me with authorized State and County staff conducting investigations pertaining to fraud, fraud prevention and misrepresentation. 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 they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six (6) months after my benefits stop.

 **SIGN ON BACK** 

FOR OFFICE USE ONLY	
Date Applied _____	
Registration # _____	

NFC-ABD-SP-0217

SECTION 7 - RIGHTS AND RESPONSIBILITIES - continued

- I understand that by accepting NJ FamilyCare, I give the NJ Department of Human Services the right to any medical support or payments from third parties who would be legally responsible for any medical services paid by NJ FamilyCare for me or any member of my household. 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 understand that this is required to get coverage. I agree to help in obtaining medical support and payments from anyone who is legally responsible.

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)

I, by signing below, attest that I have read and agree to these statements, and that they are truthful and accurate. I fully realize that the Eligibility Determining Agency and NJ Department of Human Services rely upon the truth and accuracy of my statements.

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 _____	
Registration # _____	

NJFC-ABD-SP-0217