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) **See codes below	Birth Date MM/DD/YYYY	US Citizen? (See instructions)	Full-time Student?	Other health insurance now? (see instructions)	Other health insurance within the past 3 months? (see instructions)	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 If yes, what is the NJ FamilyCare policy number: ____________________

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

If you need to write about more children, use another piece of paper

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

▶ 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), see instructions: ____________________

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

Name of person receiving income, including children ■ Proof is required, see Instructions	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 applying: Taking prescription medicines? Yes ❑ No ❑ Receiving any medical treatment? Yes ❑ No ❑ Using any special medical equipment? Yes ❑ No ❑

Jon S. Corzine
Governor
State of New Jersey

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 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 FamilyCare program for the purpose of determining eligibility and billing the Program. I certify under penalty of law that everything on this application is true.

Sign your name here: ________________________________ Date: ____________

For Official Use Only
Enrollment Site#:____________
Policy #:____________

NJFC-APP-0906

NJFAMILYCARE
Affordable health coverage. Quality care.

1-800-701-0710 (TTY 1-800-701-0720 for hearing impaired)

NJ FamilyCare does not discriminate against anyone because of race, age, color, religion, sex, national origin, marital status, disability, or political belief.

**Complete ONE application per family.
DO NOT LEAVE ANY SPACES BLANK.
PRINT CLEARLY.**

Instructions for Completing the NJ FamilyCare Application

Section 1

Household Information:

- **Address:**
  List your home address.
  If your mailing address is different from your home address, also write your mailing address in the space provided.
- **Telephone Numbers:**
  Write your home telephone, cell phone numbers or another telephone number where we can reach you. Include area codes.
  We must have a way to reach you.

List all Parents/Guardians and all children under the age of 21 living in household:

- **Name:**
  The first adult listed will be considered the head of the household. It is important to list both parents, stepparents or guardians of the children, if they are living in the household. It is not necessary to list other adults who live in the household.
- **Social Security Number (SS#):**
  You must provide a SS# for each person applying for NJ FamilyCare. Parents of newborns must supply the SS# as soon as it is available.
- **Race/Ethnicity:**
  - If your child is a Native American Indian or Alaskan Native, please submit his/her tribal card.
- **Citizenship: To be eligible for NJ FamilyCare, applicants must be a US citizen or qualified immigrant admitted for permanent residence.**
  - **If you checked "yes"**, send any available documentation which proves the person requesting NJ FamilyCare is a U.S. citizen.
  - **If you checked "no"**, you *must* send proof of immigration status.
    Examples of acceptable proof include:
    - The front and back of a Resident Alien Card
    - The Temporary I-551 stamp on a passport or Form I-94
    - Documentation indicating refugee or asylee status.
    - Documentation indicating a parent's US military service.
- **Health Insurance:**
  - **If you checked "yes"**, you must send a copy of the front and back of the insurance card with the application. **Note: You may still qualify for NJ FamilyCare even if you have other insurance.**
- **Health Insurance within the last 3-months:**
  - **If you checked "yes"**, you must send proof that the insurance was terminated.
- **Relationship:**
  List how each child is related to the 1st and 2nd parents/guardians listed in Section 1. An example of "Other" would be a niece, nephew or grandchild.
- **Unpaid medical bills:**
  - **If you checked "yes"**, submit proof of all household income for the last three months.

Section 2

Income Information for parents/ guardians and children under 21:

- **Name of person receiving income:**
  It is important to include the names of all parents, stepparents, guardians and children between the ages of 16-20 in the household who are working.
- **Employer Name:**
  List **all** jobs and employers for each working person in the household.
  - If you are self-employed or the owner of a business, you must submit a **signed** copy of your last 1040 (including Schedule C, Form S1120, Form 1065, Schedule E, and all the other related schedules) or your last profit and loss statement.
- **Full-time or Part-time:**
  Part-time employment is less than 30 hours per week.
- **Work income per pay period before deductions:**
  - Send in one check stub that best shows your pay or other proof showing **gross** income (before deductions) for the most recent month. **Be sure to send copies of check stubs for every job listed for each working person.**
- **Other Income (not from work):**
  Indicate the **type** of other income such as:
  - Supplemental Security Income (SSI);
  - Social Security survivors/retirement;
  - Social Security disability benefits;

Other income types (continued):
- Veteran's benefits;
- Unemployment;
- State disability;
- Workers' compensation;
- Pension or annuity;
- Interest or dividends;
- Alimony you receive*;
- Child support you receive*;
- Cash from friends or family*;
- Income from rent (not what you pay); and
- All other income.

- Send in copies of check stubs from the most recent month, award letters, or some proof of each kind of income received.

***No proof required**

Section 3

HMO Selection:

For you and your child(ren) to be enrolled in NJ FamilyCare, you must pick an HMO

- **Choose an HMO:**
  See the HMO flyer in the application package for HMOs in your county.
- **Who is your Doctor?**
  If you or your child(ren) see a doctor, please list his or her name and address.

Signature:

- Read the Privacy Notice and the NJ FamilyCare Rights and Responsibilities prior to signing the application. Make sure you **SIGN** and **DATE** the application before sending it to NJ FamilyCare.

Remember to:

1. **Sign** the application.
2. **Send** proof of income (the most recent month) for each job and for all other income, including self-employment and rental income.
3. **Citizens: Send** documentation proving US citizenship for anyone applying for NJ FamilyCare.
   Non-Citizens: Send a copy of the Resident Alien Card or other immigration documentation for anyone applying for NJ FamilyCare.
4. **Send** proof of any other health insurance, or the letter you received if your health insurance ended.

Documentation must be sent.

If you wish to contact NJ FamilyCare:

✔ Call **1-800-701-0710**
(TTY 1-800-701-0720 for hearing impaired)
Mondays and Thursdays 8 a.m. to 8 p.m., and on Tuesdays, Wednesdays and Fridays 8 a.m. to 5 p.m.
We speak 150 languages.

✔ **Write to us:** **NJ FamilyCare**
P.O.Box 8367
Trenton, NJ 08650; or

✔ **Visit us online at: www.njfamilycare.org**