



# NJ FAMILY CARE

Affordable health coverage. Quality care.

## *can provide you with medical insurance for your entire family*

You may be able to receive NJ FamilyCare, free or low-cost health insurance for adults and children who meet income guidelines. Just take a few minutes to fill out this form, and mail it with the materials listed on the next page, in the enclosed postage paid envelope.

### Who Qualifies for NJ FamilyCare?

1. Single adults and couples without dependent children
2. Families with children
  - Children up to age 21
  - Parents/caretakers of children up to age 19

#### QUALIFIED APPLICANTS MUST

- ❖ Live in New Jersey; and
- ❖ Be citizens or qualified immigrants including immigrants lawfully admitted for permanent residence; and
- ❖ Meet all other requirements of the program (income, age, etc.)

1-800-701-0710

TTY 1-800-701-0720 (for Hearing Impaired Individuals)

[www.njfamilycare.org](http://www.njfamilycare.org)

*can help you provide  
medical insurance  
for your family.*

The following are examples of documentation needed to verify the information on your NJ FamilyCare application. Please send a copy from each category that applies to your application.

### AGE: (Only One)

Please send a copy of one of the items listed below to verify your child(ren)'s age who are applying for NJ FamilyCare.

- |                          |                                 |                       |   |
|--------------------------|---------------------------------|-----------------------|---|
| 1. Birth Certificate     | 4. Passport, Immigration Papers | 7. Court Records      | 10. Church Records                                |
| 2. Baptismal Certificate | 5. School Records               | 8. Voting Records     | 11. Records of Public or Private Welfare Agencies |
| 3. Driver's License      | 6. Medical Records              | 9. Employment Records |   |

### CITIZENSHIP: (Only One)

Please send a copy of one of the items listed below that indicates the immigration status and date of entry of anyone applying for NJ FamilyCare if she/he is not a U.S. born citizen.

- |   |   |                                     |
|---|---|-------------------------------------|
| 1. Certificate of Naturalization            | 3. American Indian Card with "KIC" code | 5. PERMANENT RESIDENT CARD (I-551)  |
| 2. Certificate of United States Citizenship | 4. Card I-94                            | 6. Military Papers that show status |

### PREGNANCY:

Please send a copy of a positive pregnancy test, provided by a lab or physician.

### INCOME: (Earned and Unearned)

Please send copies of any documentation needed to prove the total income received in the past month by anyone listed on the application.

- |   |   |  |                  |
|---|---|--|------------------|
| 1. Paycheck Stubs   | 3. Unemployment Income                                    | 6. Self-Employment — Copy of IRS Form 1040 and all related schedules | 8. Rental Income |
| 2. The Check or Check Stub Attached to Benefits Such as Social Security, Pensions, Annuities, Strike Benefits, VA, etc. | 4. Statement from Employer or Individual Providing Income | 7. Interest or Dividend Income from Stocks or other Investments      |                  |
|   | 5. Order of Alimony or Child Support                      |  |                  |

### FULL-TIME STUDENT:

For older children, age 16 through 20, who maybe in high school or college and are employed, please send a copy of their course schedule or other proof of school attendance.

**For additional information, please call: 1-800-701-0710  
or TTY 1-800-701-0720 (For Hearing Impaired).  
We speak 140 languages.**

If you don't understand some of the questions or need help with filling out this form, call 1-800-701-0710 or TTY 1-800-701-0720. We speak 140 languages.

## Here's How to Apply

1. Complete and return this application with copies of the following materials:
  - ☺ Proof of age for all children under the age of 21 who are applying for NJ FamilyCare
  - ☺ Proof of immigration status for non-citizens applying for NJ FamilyCare
  - ☺ Proof of full-time student status only for children ages 16 to 21, who are employed
  - ☺ Note from a doctor or lab for a family member who is pregnant (it's important — pregnant women and their babies may qualify for special benefits)
  - ☺ Proof of all household income (including children's), before deductions
    - Pay stubs that show at least one month of income **OR** a letter from your employer telling how much you've earned in the last month
    - If you are self employed, send your income tax return and all schedules you submitted to the IRS, or a letter from your accountant that includes a recent profit and loss statement for your business
    - Proof of all other income received, including such things as Social Security benefits for any family member receiving them, child support, pensions, interest income, and regular cash payments from family members
    - Proof of alimony and/or child support received or paid to others.
2. Complete and return the enclosed HMO Plan Selection Form.

## HMO Selection

NJ FamilyCare provides medical care through an Health Maintenance Organization (HMO). **THE ENCLOSED PLAN SELECTION FORM MUST BE COMPLETED TO SELECT YOUR HMO AND TO APPLY FOR NJ FAMILYCARE.**

## How did you hear about NJ FamilyCare? (check all that apply)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Clergy                 | <input type="checkbox"/> Family/friend/neighbor | <input type="checkbox"/> Newspaper             | <input type="checkbox"/> Television          |
| <input type="checkbox"/> Community organization | <input type="checkbox"/> Hospital/Clinic        | <input type="checkbox"/> Pharmacist/drug store | <input type="checkbox"/> NJ KidCare          |
| <input type="checkbox"/> Doctor                 | <input type="checkbox"/> Internet               | <input type="checkbox"/> Radio                 | <input type="checkbox"/> Other (Please list) |
| <input type="checkbox"/> Employer               | <input type="checkbox"/> Mail                   | <input type="checkbox"/> School                | _____  |

## Section 1: Household Information

Please List your Address

Home Address	Apt. No.	City	State	Zip	County
Mailing Address (If different)					

Phone Numbers: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Whose Wk No. \_\_\_\_\_

## Section 1: Household Information (Continued)

**PLEASE LIST EVERYONE LIVING IN YOUR HOUSEHOLD, BEGINNING WITH HEAD OF HOUSEHOLD.**

**\*For adult relationships (3rd column), please use the following letters as they relate to children listed:**  
 P = Parent S = Stepparent C = Grandparent or custodial relative  
 G = Guardian-unrelated U = Unrelated adult in family household  
 A = Applying as adult or couple (no children)

**For child relationships, use the following letters as they relate to the first adult listed:**  
 BC = Biological or adopted child SC = Stepchild  
 CC = Child in care or custody of relative  
 FC = Child in care or custody of non-relative

ADULTS	First Name	Last Name	* Relationship	Does this person want NJ Family Care?		Marital Status M-Married S-Single W-Widow D-Div. P-Sep.	Sex		Social Security No. (Optional for Non-Applicants)	Race Optional (see codes below)	Citizen (If NO, give details below)		Birth-Date M/D/Y
				Y	N		M	F			Y	N	
CHILDREN													

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

For any one who checked that he/she is applying for NJ FamilyCare, and who answered "NO" to the citizenship question, please give the person's name and date of entry into the country in the section below. **This information is not needed for anyone not applying for NJ FamilyCare. It will be kept completely confidential, and will be used only to determine eligibility.**

**DONT FORGET TO INCLUDE COPIES OF IMMIGRATION DOCUMENTS FOR THOSE APPLYING FOR NJ FAMILYCARE (BOTH SIDES OF PERMANENT RESIDENT ALIEN CARD AND/OR VISA).**

Name \_\_\_\_\_ Date of Entry \_\_\_\_\_      Name \_\_\_\_\_ Date of Entry \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Entry \_\_\_\_\_      Name \_\_\_\_\_ Date of Entry \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Entry \_\_\_\_\_      Name \_\_\_\_\_ Date of Entry \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Entry \_\_\_\_\_      Name \_\_\_\_\_ Date of Entry \_\_\_\_\_

**If anyone above, who is requesting NJ Family Care is undocumented, a tourist, student or visitor, please give their names:** \_\_\_\_\_

Is anyone in your household pregnant now? Yes  No  (Unborn children could increase your family size, and eligible pregnant women and their babies may have additional benefits.) If "yes," please give person's name: \_\_\_\_\_

Is she expecting more than one baby? Yes  No  If so, how many? \_\_\_\_\_

**Please include proof from a doctor or lab showing due date and number of babies expected.**



## Section 2: Household Income (Continued)

Name: \_\_\_\_\_

Income Type	Rec'd		Amount	Frequency				
	Y	N		W	B	S	M	I
Work Income			\$					
Name & Phone				Full Time <input type="checkbox"/>				
No. of Employer				Part Time <input type="checkbox"/>				
SSI Benefits								
SS Survivors								
SS Disability								
Unemployment								
State Disability								
Worker's Comp.								
Veteran's Benefits								
Pension/Annuity								
Interest/Dividends								
Alimony								
Child Support								
Cash from family								
Rental Income								
Self Employment								
Other (explain below)								

1. Please explain any income received irregularly.  
\_\_\_\_\_
2. Please explain any income you will not continue to receive in the future.  
\_\_\_\_\_
3. Retroactive eligibility is eligibility for the three months prior to the month you apply. If anyone listed had unpaid medical services by a program provider in those months, the bills **may** be paid. If you are interested in retroactive eligibility, check here  and include proof of income for all three of those months. **NOTE: Choosing this option does not guarantee medical bills will be paid. Only people who qualify for Plan A, and meet Plan A requirements in those months may have retroactive eligibility.**  
\_\_\_\_\_
4. Does anyone in your household pay child support or alimony to someone in another household, or support someone in another household? Yes  No

If so, who \_\_\_\_\_ How much is paid monthly? \$ \_\_\_\_\_ Please provide documentation (court order, tax forms showing support, etc.).

**DON'T FORGET TO INCLUDE PROOF OF ALL ITEMS OF INCOME DECLARED ABOVE (COPIES OF PAYSTUBS, SSA AWARD LETTERS, ETC.).**

## Section 3: Child Support and Medical Support Information

If this section applies to you, you must answer these questions. If you do not know an answer, please answer "Don't know." **NOTE: In Questions 3, 4 and 5, enter the letter for the individual listed in Question #1.**

1. Does a parent of any listed child(ren) live outside your home? Yes  No  If yes, where:
  - a. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Parent of: \_\_\_\_\_
  - b. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Parent of: \_\_\_\_\_
  - c. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Parent of: \_\_\_\_\_
2. Have you tried to get child support for your children? Yes  No  If yes, are you receiving it? Yes  No  If not, please explain why below. **REMINDER: If you answered yes, did you list it as income?**  
\_\_\_\_\_
3. Have you tried to get medical support for your children? Yes  No  If yes, are you receiving it? Yes  No  If you are receiving it, in what form (Insurance, direct payment, other)? \_\_\_\_\_ If you are not, why? \_\_\_\_\_ If it is in the form of insurance, please give:
 

Insurer's name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Policy No. \_\_\_\_\_  
Child(ren) covered: \_\_\_\_\_ Parent providing (a, b or c) \_\_\_\_\_

Insurer's name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Policy No. \_\_\_\_\_  
Child(ren) covered: \_\_\_\_\_ Parent providing (a, b or c) \_\_\_\_\_
4. If you know the absent parent's place of employment, please give the employer's name and Phone No.:
  - a. Employer: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
  - b. Employer: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
  - c. Employer: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
5. If you know the Social Security Number(s) of the absent parent(s), please give it/them here.
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_

## Section 4: Health Insurance

If you have other health insurance, your family may still be eligible for NJ FamilyCare.

- If anyone listed in Section 1, who wishes NJ FamilyCare, has other health insurance now, please give their names, below:  
 Name(s) of Insured \_\_\_\_\_  
 Insurer \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ ID No. \_\_\_\_\_ or Policy No. \_\_\_\_\_  
 Is this insurance provided through an employer? Yes  No
- If anyone listed in Section 1 is currently receiving Medicaid, please give names below:  
 Name \_\_\_\_\_ ID No. \_\_\_\_\_ Name \_\_\_\_\_ ID No. \_\_\_\_\_  
 Name \_\_\_\_\_ ID No. \_\_\_\_\_ Name \_\_\_\_\_ ID No. \_\_\_\_\_  
 Name \_\_\_\_\_ ID No. \_\_\_\_\_ Name \_\_\_\_\_ ID No. \_\_\_\_\_
- If anyone listed in Section 1, who wishes NJ FamilyCare, lost health insurance in the last six months, please give their names below:  
 Name(s) \_\_\_\_\_  
 Insurer \_\_\_\_\_ ID No. or Policy No. \_\_\_\_\_ Insurer Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Termination Date \_\_\_\_\_ (Show proof of termination) Was it through an employer? Yes  No   
 Was it COBRA coverage? Yes  No  Why was it dropped? Changed jobs  Laid off   
 Other (explain below)  \_\_\_\_\_
- Could you get health insurance through your employer if you wanted it? Yes  No
- Is there a lawsuit, worker's compensation award or insurance payment pending for anyone in the household applying for NJ FamilyCare?  
 Yes  No  If so, who \_\_\_\_\_ Please give name and address of attorney, below: \_\_\_\_\_

## Your Rights and Responsibilities

- ◆ I have completed this application so it can be determined if my family can receive NJ FamilyCare health insurance. I understand that NJ FamilyCare will follow federal and state laws in reviewing my application, and I have the right to question any decisions made.
- ◆ I understand that all information is private, and that I may be asked to provide additional information.
- ◆ I understand that I must report any change in information to NJ FamilyCare, including additional children, or other household members, change of address, changes in household income, or health insurance obtained through an employer or other source.
- ◆ I understand the information that I have given is subject to verification and, by signing this document, I give permission to contact any agencies, including but not limited to, Social Security and wage benefits files, and state wage and unemployment files, for the sole purpose of verifying information I have provided. Information given will be used only in connection with this application for NJ FamilyCare.
- ◆ I understand this insurance will need to be renewed annually.
- ◆ I understand that anyone who knowingly gives false information on this application is committing a crime and can be punished under federal and state laws. I agree that everything on this application form is the truth, to the best of my knowledge.
- ◆ I understand the NJ FamilyCare program may release information about the status of my application to the enrollment site that helped me complete it.
- ◆ I understand that, after my application is completed and reviewed, I will be given the most complete coverage for which I qualify.
- ◆ I understand that, by signing this application, I am authorized to sign for all persons listed.
- ◆ *Any rights to payment for medical care from any third party are hereby assigned to the Commissioner of Human Services as a condition of eligibility.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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



Affordable health coverage. Quality care.

New Jersey Department of Human Services  
 Christie Whitman, Governor  
 Michele K. Guhl, Commissioner

1-800-701-0710

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

NJ Family Care, P.O. Box 4818, Trenton, NJ 08650-8955

www.njfamilycare.org

Tuesday, Wednesday & Friday: 8:30 AM to 5 PM

Monday & Thursday: 8:30 AM to 7 PM

For Agency Use Only

Enrollment Site #:

Agency Employee:

Date: