NJ FAMILY CARE
Affordable health coverage. Quality care.

Renew Your Medicaid Benefits

Date:

RE:
Case #:

Dear NJ FamilyCare Aged, Blind, Disabled Program Beneficiary:

It is time to renew! You must respond by or lose your benefits.

1. Complete the application, answer all questions and sign the last page of the application after reading the Rights and Responsibilities section. Be sure to tell us about any changes since your last eligibility determination for you and your spouse.

2. Provide copies of the following documents to verify eligibility.

All beneficiaries:
- Income
- Most recent statement for all bank accounts (including accounts closed since your last determination)

If applicable:
- Changes in living expenses
- Personal Needs Allowance (PNA) account
- All Qualified Income Trust/Special Needs Trust bank statements since your last determination
- Current cash surrender value of life insurance policy
- Plan of liquidation documents (for example: listing agreement, closing settlement)
- Changes in Medicare or other health insurance premiums

3. Mail the application and all supporting documents in the envelope provided.

You will receive a letter when your Renewal Application is processed. If you have any questions or need help, call at extension .

Sincerely,

NJ FamilyCare Aged, Blind, Disabled Programs

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

RENEWAL APPLICATION

INSTRUCTIONS:

This form must be completed to continue benefits. The Beneficiary is the person already enrolled in the NJ FamilyCare Aged, Blind, Disabled programs.

SECTION 1 Demographic Information

PLEASE PRINT

Beneficiary's Name:

_______________ _______________ _______________
Last First Middle

Home Address:

_______________ _______________ _______ _______
Street City State Zip Code

Current Mailing Address (if different from above):

_______________ _______________ _______ _______
Street City State Zip Code

Is Beneficiary living in a facility? ❑ Yes ❑ No

Beneficiary's Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Medicare ID Number: _______________

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

❑ Widowed, Spouse's Date of Death _______________. ❑ Separated, Date _______________

❑ Child (under age 19)

Spouse's Address (last known): _______________ _______________ _______ _______
Street City State Zip Code

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

If not a citizen, does the Beneficiary 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

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SECTION 1 - DEMOGRAPHIC INFORMATION - continued

❑ Yes, enter information below: ❑ No

Immigration document type________________________ Status type (optional)____________________

Beneficiary'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 Beneficiary lived in the US since 1996? ❑ Yes ❑ No

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

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

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 2 Changes since the last eligibility determination

❑ Address
❑ Liquidation of Resource
❑ Burial Arrangements
❑ Marital Status
❑ Income
❑ Life Insurance
❑ Health Insurance
❑ Household Composition
❑ Litigation
❑ Disability
❑ Employment
❑ Other

Explain:____

____

____

____

____

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SECTION 2 - CHANGES SINCE THE LAST ELIGIBILITY DETERMINATION - continued

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 Beneficiary need "nursing home like" services, Long Term Services and Supports, such as dressing, bathing and mobility assistance? See Brochure for more details. ❑ Yes ❑ No

❑ **Beneficiary does not have any changes.**

SECTION 3 Beneficiary's Income

Tell us about the income that Beneficiary receives. Income is cash or in kind support that can be used for food and shelter. Income includes but is not limited to work income, pensions, alimony, government benefits such as Social Security and Veteran's Benefits. Provide copies.

Source	Last monthly Amount

❑ **Beneficiary does not have any income.**

SECTION 4 Beneficiary's Resources

Tell us about resources owned in full or part by the Beneficiary. This includes but is not limited to, checking, savings, business checking accounts, Certificate of Deposit (CD), Holiday/Vacation club accounts, Credit Union accounts, Burial Accounts/Funeral Trusts owned or closed by the Beneficiary. Provide copies.

Type of Resource	Name of Bank/Institution	Current value	If closed, date closed and value	
		$		$
		$		$
		$		$
		$		$

❑ **Beneficiary does not have any resources.**

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SECTION 5 Spouse's Income

Source	Last monthly amount
______	$ ______
______	$ ______
______	$ ______
______	$ ______

❑ **Spouse does not have any income.**

SECTION 6 Spouse's Resources

Type of Resource	Name of Bank/Institution	Current value	If closed, date closed and value	
______	______	$ ______	______	$ ______
______	______	$ ______	______	$ ______
______	______	$ ______	______	$ ______
______	______	$ ______	______	$ ______

❑ **Spouse does not have any resources.**

SECTION 7 For Beneficiaries with a Trust including Testamentory, Special Needs and Qualified Income Trust(s), provide:

1. Trustee Name ______________________________

2. Trustee Address:

______________ ______________ ______ ______
Street City State Zip Code

Trustee Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

3. Copies of all statements for the previous twelve months.

❑ **Beneficiary does not have a Trust.**

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SECTION 8 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

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SECTION 8 - 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, and any time after, my first date of applying for benefits.

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SECTION 8 - APPLICANT AND BENEFICIARY RIGHTS AND RESPONSIBILITIES - continued

- 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).

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SECTION 9 Applicant Signature

The person who filled out this renewal application must sign this renewal 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 renewal 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 can not be considered until it is received by the Eligibility Determining Agency.

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