



Applying for Services from the NJ Division of Developmental Disabilities

Application for Eligibility, including all signed forms and related documentation, must be mailed to the Community Services Office (CSO) that serves the Applicant’s county of residence (*see page 2 for CSO locations and counties served*).

- An individual must be **18 years of age or older to be evaluated by DDD for functional eligibility for services**
- An individual must be **21 years of age or older and be Medicaid eligible to receive services from DDD**

A. APPLICATION CHECKLIST

Any applicant who is 18 years of age or older and legally his/her own guardian must sign the required forms. If an applicant is receiving assistance completing the application, the person assisting should sign on the witness line.

- APPLICATION FOR ELIGIBILITY (5 pages)**
- NOTICE OF PRIVACY PRACTICES (6 pages):** *please read and keep for applicant’s records*
- ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (1 page):** *after reading the Notice of Privacy Practices, sign and return with application*
- AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS (2 pages):** *identifies people DDD can speak with regarding applicant’s health information – can include family members, health care professionals and emergency contacts; complete, sign and return with application*
- AUTHORIZATION FOR RELEASE OF RECORDS (2 pages):** *gives permission to people/organizations chosen by the applicant to send copies of health records to DDD; complete, sign and return with application*
- CONSENT FOR RELEASE OF INFORMATION TO DDD (1 page):** *for use with Section B documents – additional pages can be requested as needed; complete, sign and return with application*
- NEW JERSEY VOTER REGISTRATION FORM (1 page):** *an individual can choose to register to vote if he/she is 18 years of age or older; a U.S. citizen; a resident of New Jersey; and not currently serving a sentence or on probation or parole. Complete, sign and return with application.*

B. DOCUMENTATION OF DEVELOPMENTAL DISABILITY

Include as many of the available documents below as you are able that relate to the applicant’s developmental disability. The more documentation that is provided, the easier it is for DDD to process the application.

Necessary	Helpful But Not Necessary
Medical Documentation of Disability	Most recent IEP
Most Recent Psychological Evaluation (+ IQ Scores)	Speech Therapy Evaluations
Neurological Evaluations	Occupational Therapy Evaluations
Most Recent Child Study Team or School Reports	Physical Therapy Evaluations
Psychiatric Evaluations	Hospital Records
DVRS Assessments	Social Summaries
All Available Psychological Reports	

C. LEGAL DOCUMENTATION OF AGE, US CITIZENSHIP, NJ RESIDENCY

(Note: applicant must be a permanent resident of New Jersey to apply for services through DDD)

1. Photocopy of Birth Certificate	
2. Photocopy of Social Security Card or Proof of U.S. Citizenship or Green Card	
3. Photocopy of one of the following:	<ul style="list-style-type: none"> -Current photo identification Motor Vehicle Commission -Pay Stub -W2 form -Real Estate Tax Bill -Permanent Change of Station Orders to New Jersey (if individual's legal guardian is in the U.S. Military Service) -Voter Registration Form

D. OTHER DOCUMENTATION (when applicable)

Photocopy of Guardianship Order	Supplemental Security Income (SSI) annual award letter
Photocopy of Medicaid Card	Letter certifying Medicaid eligibility
Division of Vocational Rehabilitation Services (DVRS) Records/Evaluations (F3 form)	

E. NJ CAT ASSESSMENT

Once sections A-D have been provided to and reviewed by DDD, and all of the above information has been satisfied (up to and including face-to-face interview, if deemed appropriate by intake staff), the New Jersey Comprehensive Assessment Tool (NJ CAT) will be requested. The agency that administers the NJ CAT is the Developmental Disabilities Planning Institute (DDPI) at Rutgers.

DDD COMMUNITY SERVICES OFFICES

Counties Served	Office Location and Phone Number
Morris, Sussex, Warren	Flanders Office: 1 Laurel Drive Flanders, NJ 07836 Phone: 973.927.2600
Bergen, Hudson, Passaic	Paterson Office: 100 Hamilton Plaza, 7th Floor Paterson, NJ 07505 Phone: 973.977.4004
Essex	Newark Office: 153 Halsey St., 2nd FL, PO Box 47013, Newark, NJ 07101 Phone: 973.693.5080
Union, Somerset	Plainfield Office: 110 East 5th Street, Plainfield, NJ 07060 Phone: 908.226.7800
Ocean, Monmouth	Freehold Office: Juniper Plaza, Suite 1 – 5, 3499 Route 9 North, Freehold, NJ 07728 Phone: 732.863.4500
Hunterdon, Mercer, Middlesex	Trenton Office: 11A Quakerbridge Plaza, PO Box 705, Trenton, NJ 08619 Phone: 800.832.9173
Atlantic, Cape May, Cumberland, Salem	Mays Landing Office: 5218 Atlantic Avenue, Suite 205, Mays Landing, NJ 08330 Phone: 609.476.5200
Burlington, Camden, Gloucester	Voorhees Office: 2 Echelon Plaza, 221 Laurel Rd, Suite 210, Voorhees, NJ 08043 Phone: 856.770.5900

Applicant Information

Applicant Name: _____

Date of Birth: _____

Home Address: _____

Phone Number: _____

Email Address: _____

Application Completed By *(if not by completed by Applicant):*

Name: _____

Home Address: _____

Phone Number: _____

Email Address: _____

Can DDD contact you, if necessary, regarding this application? Yes No

Does the applicant have a Legal Guardian?* Yes No

***If yes, please complete the section below and provide a copy of the Guardianship Order with the application*

Legal Guardian Name: _____

Relationship to Applicant: _____

Address: _____

Phone Number: _____

Email Address: _____

(1) APPLICANT RESIDENCY AND OCCUPATION INFORMATION

Place of birth (hospital, city, state, or country if born outside the U.S.):

If born outside of the U.S., is Applicant a U.S. Citizen? Yes No

If No, does Applicant have a valid Green Card? Yes No

If Applicant has a legal guardian, is the legal guardian a permanent legal resident of New Jersey? Yes No

Is Applicant currently receiving services from any other federal, state or local agencies? Yes No

Agency Name: _____ Phone: _____

Address: _____

Agency Name: _____ Phone: _____

Address: _____

Agency Name: _____ Phone: _____

Address: _____

Does Applicant live in a Residential Program? Yes No

(For example, DCF, DCPP, Boarding Home, Homeless Shelter)

Residence Name: _____ Residence Type: _____

Address: _____

Does Applicant attend school or day program, and/or is Applicant employed? Yes No

Program Type: _____ Name: _____

Address: _____

Contact Name and Phone Number: _____

Program Type: _____ Name: _____

Address: _____

Contact Name and Phone Number: _____

Has the NJ Division of Vocational Rehabilitation Services (DVRS) assisted Applicant with employment or day services?

Yes No

(2) APPLICANT MEDICAID AND SOCIAL SECURITY BENEFIT INFORMATION

Does Applicant have Medicaid? Yes No

If not, has Applicant applied for Medicaid? Yes No

(To receive services through DDD, Applicant must obtain Medicaid)

Does Applicant receive Social Security Disability Insurance (SSDI) benefits? Yes No

If yes, amount received per month: \$ _____

If no, what is SSDI application status? Never Applied Application Pending Ineligible

Does Applicant receive Supplemental Security Income (SSI) benefits? Yes No

If yes, amount received per month: \$ _____

If no, what is SSI application status? Never Applied Application Pending Ineligible

If Applicant receives SSDI or SSI, is there a Representative Payee? Yes No

Payee Name: _____ Benefit Type: _____

Address: _____ Phone: _____

Relationship to Applicant: _____

Payee Name: _____ Benefit Type: _____

Address: _____ Phone: _____

Relationship to Applicant: _____

(3) APPLICANT FAMILY AND HOUSEHOLD INFORMATION

Father: Living Deceased

If living, please complete the following:

Name: _____ Date of Birth: _____

Address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email Address: _____

Marital Status: _____

Is father a Veteran? Yes No

Is father an emergency contact? Yes No

Mother: Living Deceased

If living, please complete the following:

Name: _____ Date of Birth: _____

Address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email Address: _____

Marital Status: _____ Maiden Name, if applicable: _____

Is mother a Veteran? Yes No Is mother an emergency contact? Yes No

Other Members of Applicant's Household *(do not include parents if they are listed above)*

Name: _____

Date of Birth: _____ Relationship: _____

Name: _____

Date of Birth: _____ Relationship: _____

Name: _____

Date of Birth: _____ Relationship: _____

Your Information. Your Rights. Our Responsibilities.

This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services and describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information with other healthcare professionals who are either part of the Department of Human Services or who are outside of the Department of Human Services to determine how to diagnose or treat you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Business Associates

There are some services provided in our organization through contracts with business associates:

- Examples include our accountants, consultants and attorneys
- We may disclose your health information to them so that they can perform the job we've asked them to do
- However, we require that the business associates appropriately safeguard your information

Do research

We can use or share your information for health research when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this Notice: September 23, 2013

New Jersey Department of Human Services
DIVISION OF DEVELOPMENTAL DISABILITIES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This **ACKNOWLEDGEMENT OF RECEIPT** must be signed upon receipt of the Notice of Privacy Practices and returned to the New Jersey Division of Developmental Disabilities.

I, _____ (print name)

Hereby acknowledge that I received the **Notice of Privacy Practices** on _____
(date)

I am: *(please check one)*

Applicant

Parent

Legal Guardian

Applicant, Parent or Legal Guardian Signature or Mark*

Date

If signed by Legal Guardian:

Applicant Name (please print)

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable

Witness Name (please print)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name: _____

Date of Birth: _____

1. Person(s) authorized to use, disclose or receive information *(include legal guardian if applicable)*:

PRIMARY CONTACT	ALTERNATE CONTACT
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Alternate Phone: _____	Alternative Phone: _____
Relationship: _____	Relationship: _____
OTHER CONTACT	OTHER CONTACT
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Alternate Phone: _____	Alternative Phone: _____
Relationship: _____	Relationship: _____

2. I authorize DDD staff to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization.
3. I authorize DDD staff to provide the minimum necessary health information to the contacts listed above and/or other individuals who are permitted to visit.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.
7. This authorization expires on _____ or one year from the date of the individual's/legal guardian's signature.
8. A complete copy of this form will be maintained in the applicant's record.
9. **To Legal Guardians:** If the individual receiving/applying for services is 18 years of age or older and you have indicated that you are the individual's Legal Guardian, then you must attach a copy of a valid **Appointment of Guardianship** to this form.

Individual or Legal Guardian Signature or Mark*

Date

Legal Guardian Name, if applicable (please print)

Please attach a valid Appointment of Guardianship to this form, if applicable

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable

Witness Name (please print)

Legal Authority for this Request:

- These are my records, and I am a legally competent adult.
- I am the Legal Guardian of the individual whose records are being requested. *A copy of valid Appointment of Guardianship is attached.*
- I am a parent of the individual whose records are being requested and I have Power of Attorney for the individual, which authorizes me to be able to request the individual’s medical records. *A copy of valid Power of Attorney is attached.*

Understandings and Agreements about this Authorization:

1. This authorization is voluntary and I understand that DDD cannot condition treatment based on the signing of this authorization, unless the authorization is: (a) for research-related treatment, or (b) solely for the purpose of creating health information for use by/disclosure to a third party.
2. This authorization will expire on _____ (date to be determined by person signing this form) or one year from the date of my signature below.
3. I understand I may revoke this authorization at any time by notifying DDD in writing, and my written revocation will not have any effect on any actions taken prior to the time DDD received the written revocation.
4. I agree to waive all claims against the DDD facility/agency for release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by DDD if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or business associate that has a contract with DDD.
6. I understand that if I request that records be copied and sent to me, DDD will make a good faith effort to send those records to me within a reasonable timeframe.
7. I understand that if I wish to have copies of the records made, DDD may assess a fee for copying the records.

Signature (or mark*) of Individual, Legal Guardian or Power of Attorney (please circle one) making this Request

Date **Phone Number**

Name of Person Making this Request (please print): _____

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable

Witness Name (please print)

If Requestor is the Legal Guardian or Power of Attorney for the Individual, a copy of valid Appointment of Guardianship or Power of Attorney must be attached.

New Jersey Department of Human Services
DIVISION OF DEVELOPMENTAL DISABILITIES

**CONSENT FOR RELEASE OF INFORMATION
TO THE NJ DIVISION OF DEVELOPMENTAL DISABILITIES**

I, _____
(Individual, Legal Guardian or Power of Attorney Name)

Do hereby grant permission for _____
(Name of individual, institution, agency, or other holder of requested information)

To release the report(s), evaluations(s), summaries or other information described below regarding the Application for Eligibility for services through the NJ Division of Developmental Disabilities of:

Applicant Name (please print): _____

Information to be released:

Information is to be released to:

_____, Intake Worker

NJ Division of Developmental Disabilities

Signature or Mark*: _____ Date: _____

If other than applicant, relationship to applicant: _____

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable: _____

Witness Name (please print): _____

The information received through this release is subject to the confidentiality regulations of the Division and cannot be released outside the Division without written permission unless otherwise provided by N.J.A.C. 10:41et seq.



New Jersey Voter Registration Application

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

1 Check boxes that apply: <input type="checkbox"/> New Registration <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Signature Update or Non-affiliation Change <input type="checkbox"/> Political Party Affiliation						FOR OFFICIAL USE ONLY			
2 Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, DO NOT complete this form)		Are you at least 17 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, DO NOT complete this form)					Clerk		
3 Last Name		First Name		Middle Name or Initial	Suffix (Jr., Sr., III)		Registration #		
4 Date of Birth							Office Time Stamp		
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. ____ _					
<input type="checkbox"/> "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."									
6 Home Address (DO NOT use PO Box)			Apt.	Municipality	County		State	Zip Code	
7 Mailing Address if different from above			Apt.	Municipality	County		State	Zip Code	
8 Last Address Registered to Vote (DO NOT use PO Box)			Apt.	Municipality	County		State	Zip Code	<input type="checkbox"/> by mail <input type="checkbox"/> in person
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) <input type="checkbox"/> Yes, the party name is _____ <input type="checkbox"/> No, I do not wish to be affiliated with any political party.									
11 Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Declaration - I swear or affirm that: <input checked="" type="checkbox"/> I am a U.S. Citizen <input checked="" type="checkbox"/> I live at the above address <input checked="" type="checkbox"/> I am at least 17 years old, and understand that I may not vote until reaching the age of 18.		<input checked="" type="checkbox"/> I will have resided in the State and county at least 30 days before the next election <input checked="" type="checkbox"/> I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws		<input checked="" type="checkbox"/> 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

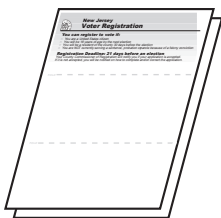
POSTAGE WILL BE PAID BY ADDRESSEE

DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

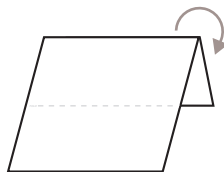


2 FOLD

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



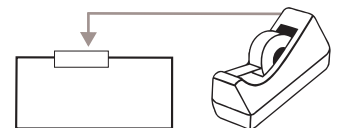
Put both pages
together as shown



1 fold top down



2 fold bottom up



3 Tape top shut

HERE TAP **3**