Application for ABD Medicaid as a Disabled Adult Child (DAC)

NJ FAMILYCARE
Affordable health coverage. Quality care.

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

NJ FamilyCare Aged, Blind, Disabled Programs APPLICATION

SECTION 1 Applicant

Applicant's Name: _____ _____ _____ _____
Last First Middle Maiden Name

Home Address: _____ _____ _____ _____
Street City State Zip Code

Current Mailing Address (if different from above):

_____ _____ _____ _____
Street City State Zip Code

If Applicant has not lived at the Home Address for 5 years, tell us the previous address:
(Attach additional information if needed)

_____ _____ _____ _____
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 Supports (see Brochure) ☐ Yes ☐ No

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

Has the applicant applied for Supplemental Security Income (SSI)?
☐ Yes If yes, when _____ ☐ No
mm/dd/yyyy

SECTION 2 Demographic Information for the Applicant

Date of Birth: _____ Sex: ☐ Male ☐ Female
mm/dd/yyyy

Citizenship Status: ☐ US Citizen ☐ Refugee ☐ Asylee ☐ Legal Alien _____
☐ Not Lawfully Admitted Date of Entry (mm/dd/yyyy)

Place of Birth: City _____ State _____ Country _____

Social Security Number: _____

Medicare ID Number: _____

Marital Status: ☐ Single ☐ Married, Date _____ ☐ Divorced, Date _____
☐ Widowed ☐ Separated, Date _____ ☐ Child (under age 19)

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HMO choice _____

Date Applied _____

Registration # _____

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SECTION 3 Spouse's Name

Also include if divorced, separated or widowed in the past 5 years.

Spouse's Name: _____ _____ _____ _____
Last First Middle Maiden Name

Spouse's Date of Birth: _____
mm/dd/yyyy

Spouse's Social Security Number: _____

Is this person also applying for the Aged, Blind, Disabled Programs?

☐ No ☐ Yes, please complete the Spouse Information form.

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: _____

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Date Applied _____

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SECTION 5 Health Insurance Information

☐ **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

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 New Jersey 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(s).

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SECTION 6 Living Arrangements

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: Living Arrangement: _____

List other people living with the Applicant; include name, age and relationship

SECTION 7 Income Information

This section talks about the income that the Applicant receives. Income is any cash or in kind support that can be used for food or shelter.

Income can be wages, tips, and commissions. Income can also be government benefits (such as Social Security Benefit), interest or dividends.

☐ I do not have any income. If not, how do you pay your bills?

Current Job & Income Information

Does the Applicant have any income from employment? ☐ Yes ☐ No

☐ **Employed**
If Applicant is currently employed, tell us about Applicant's income. Start with question 1.

☐ **Self-employed**
Skip to question 10.

☐ **Not employed**
Skip to question 11.

CURRENT JOB 1:

1. Employer name and address

2. Employer phone number _____

3. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly $ _____

4. Average hours worked each WEEK _____

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CURRENT JOB 2:

(If the Applicant has more jobs and needs more space, attach another sheet of paper.)

5. Employer name and address

6. Employer phone number _____

7. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $ _____

8. Average hours worked each WEEK _____

9. **In the past year, did the Applicant:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

10. **If self-employed, answer the following questions:**

    a. Type of work _____

    b. How much net income (profits once business expenses are paid) will the Applicant get from this self-employment this month? $_____

11. **OTHER INCOME THIS MONTH:**

Check all that apply, and give the amount and how often does the Applicant get it.

☐ None			
☐ Unemployment	$_____	How often?	_____
☐ Pensions	$_____	How often?	_____
☐ Social Security	$_____	How often?	_____
☐ Retirement accounts	$_____	How often?	_____
☐ Alimony received	$_____	How often?	_____
☐ Child Support	$_____	How often?	_____
☐ Work Compensation/ Disability	$_____	How often?	_____
☐ Inheritance	$_____	How often?	_____
☐ Net rental/royalty	$_____	How often?	_____
☐ Annuity	$_____	How often?	_____
☐ Other income	$_____	How often?	_____

12. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next page.**

Your total income **this year** **$** _____

Your total income **next** year (if you think it will be different) **$** _____

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Date Applied _____

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SECTION 7a Spouse's Income

Please complete the following section with all information on Spouse's income

Current Job & Income Information

☐ **Employed**
If Spouse is currently employed, tell us about Spouse's income. Start with question 13.

☐ **Self-employed**
Skip to question 22.

☐ **Not employed**
Skip to question 23.

CURRENT JOB 1:

13. Employer name and address

14. Employer phone number _____

15. Wages/tips (before taxes)
☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

16. Average hours worked each WEEK _____

CURRENT JOB 2:

(If the Spouse has more jobs and need more space, attach another sheet of paper.)

17. Employer name and address

18. Employer phone number _____

19. Wages/tips (before taxes)
☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

20. Average hours worked each WEEK _____

21. **In the past year, did the Spouse:**
☐ Change jobs ☐ Stop working
☐ Start working fewer hours ☐ None of these

22. **If Spouse is self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will the Spouse get from this self-employment this month? $_____

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23. **OTHER INCOME THIS MONTH:**

Check all that apply, and give the amount and how often does the Spouse get it.

- ☐ None
- ☐ Unemployment $_____ How often? _____
- ☐ Pensions $_____ How often? _____
- ☐ Social Security $_____ How often? _____
- ☐ Retirement accounts $_____ How often? _____
- ☐ Alimony received $_____ How often? _____
- ☐ Child Support $_____ How often? _____
- ☐ Work Compensation/ Disability $_____ How often? _____
- ☐ Inheritance $_____ How often? _____
- ☐ Net rental/royalty $_____ How often? _____
- ☐ Annuity $_____ How often? _____
- ☐ Other income $_____ How often? _____

24. **YEARLY INCOME**:

Complete only if your income changes from month to month.
If you don't expect changes to your Spouse's income, skip to the next page.

Spouse's total income **this year** **$** _____

Spouse's total income **next** year (if you think it will be different) **$** _____

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SECTION 8 Resources for Applicant and Applicant's Spouse

Please detail all resources owned in full or in part by the Applicant, and/or the Applicant's Spouse. ☐ Cash on hand $ _____

ACCOUNTS: This includes but is not limited to, checking, savings, business checking accounts, ABLE Accounts, Certificates of Deposit (CD), Holiday/Vacation club accounts, Credit Union accounts, Burial Accounts/Funeral Trusts owned or closed by the Applicant and/or Applicant's Spouse within 60 months of application date.

Account Name _____

Bank Address _____

Name(s) on Account _____

Account or Certificate # _____ Current Value _____

If Closed, Date Closed & Value _____

Account Name _____

Bank Address _____

Name(s) on Account _____

Account or Certificate # _____ Current Value _____

If Closed, Date Closed & Value _____

Account Name _____

Bank Address _____

Name(s) on Account _____

Account or Certificate # _____ Current Value _____

If Closed, Date Closed & Value _____

Account Name _____

Bank Address _____

Name(s) on Account _____

Account or Certificate # _____ Current Value _____

If Closed, Date Closed & Value _____

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INVESTMENTS: Including but not limited to: Individual Retirement Accounts (IRAs), Keogh Accounts (401K), Retirement Plans (403B), Land/Mineral Rights, Business Equipment and Inventory, Promissory Notes and Contracts, Stocks, Bonds owned or traded/closed by the Applicant and/or Applicant's Spouse within 60 months of application date.

No Investments ☐

Type of Investment _____
Company _____
Account # _____ Current Value _____
If Closed, Date Closed & Value _____

Type of Investment _____
Company _____
Account # _____ Current Value _____
If Closed, Date Closed & Value _____

Type of Investment _____
Company _____
Account # _____ Current Value _____
If Closed, Date Closed & Value _____

PROPERTY: Properties owned solely by the Applicant, with the Applicant's Spouse and/or with others (including but not limited to Other Homes, Land, Buildings, Time Shares, Life Estates or sold within the last 60 months).

No Property ☐

Type of Real Estate _____
Address _____
Liens, Mortgages or Incumbrances _____ Fair Market Value_____
Owners _____ If Sold, Date _____

Type of Real Estate _____
Address _____
Liens, Mortgages or Incumbrances _____ Fair Market Value_____
Owners _____ If Sold, Date _____

Type of Real Estate _____
Address _____
Liens, Mortgages or Incumbrances _____ Fair Market Value_____
Owners _____ If Sold, Date _____

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LIFE INSURANCE POLICIES

List all life insurance policies owned by the Applicant and/or Applicant's Spouse or for which the Applicant(s) are named insured

No Life Insurance ☐

Owner _____
Insured _____
Insurance Company _____
Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Owner _____
Insured _____
Insurance Company _____
Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Owner _____
Insured _____
Insurance Company _____
Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Does the Applicant have any knowledge of being named a beneficiary on someone else's policy? ☐ Yes ☐ No

VEHICLES: List all vehicles owned by the Applicant and/or Applicant's Spouse, applying for benefits. List all types of vehicles, including but not limited to, cars, vans, trucks, motor homes, motorcycles, boats, etc.

No Vehicles ☐

Owner_____
Year/Make _____ Model/Style _____
Primary Use _____ Amount Owed _____

Owner_____
Year/Make _____ Model/Style _____
Primary Use _____ Amount Owed _____

Owner_____
Year/Make _____ Model/Style _____
Primary Use _____ Amount Owed _____

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TRUSTS

Testamentory Trust ☐ Special Needs Trust ☐ Qualified Income Trust ☐

Grantor _____

Trustee _____

Beneficiary _____

Trust was funded by ☐ Applicant ☐ Inheritance ☐ Will ☐ Lawsuit ☐ Other

Tax ID# _____ Date trust was initially funded _____

Burial Arrangements

Does the Applicant own any prepaid burial contracts that are irrevocable or revocable?

☐ Yes If yes, please send contract. ☐ No

☐ Burial plots

☐ Account set aside for burial Account #_____ Value _____

Identified Funeral Home (name and address) _____

Has the Applicant or anyone else set up a burial arrangement or contract through a life insurance policy? ☐ Yes If yes, please send policy ☐ No

OTHER RESOURCES NOT LISTED _____

Has the Applicant established a Plan of Liquidation for any of the resources in Section 7? ☐ Yes ☐ No

SECTION 9 Transfers

Did the Applicant and/or Applicant's Spouse trade, give away, or sell resources in which the Applicant and/or Applicant's Spouse had an interest within the last 60 months, including but not limited to cash, real estate, vehicles, businesses, stocks, bank account?

☐ Yes If yes, complete the information below for each transfer ☐ No

Item Transferred_____Transfer Date_____

Market Value _____ Amount Received _____

Item Transferred_____Transfer Date_____

Market Value _____ Amount Received _____

Item Transferred_____Transfer Date_____

Market Value _____ Amount Received _____

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SECTION 10 Legal Issues

Are there any pending claims such as lawsuits, divorce settlements, inheritance, accident claims, Medical Malpractice or other claims? ☐ Yes ☐ No

If Yes, provide details of the claims including but not limited to date monies were received and type of claim.

Attorney's Name _____

Attorney's Phone Number _____

Attorney's Address _____

Will the Applicant and/or Applicant's Spouse file a lawsuit in the future? ☐ Yes ☐ No

Does anyone owe the Applicant and/or the Applicant's Spouse money, for example loans, promissory notes and/or mortgages? ☐ Yes ☐ No

If yes, provide details regarding these arrangements

Has the Applicant received medical services within the past 3 months?

☐ Yes ☐ No

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SECTION 11 Select the Applicant's Health Plan

Choose a Health Plan from the list below. If the Applicant does not choose now, the Applicant will have an opportunity to select a Health Plan before enrollment occurs. The Applicant must be enrolled in a Health Plan to receive all of the services offered through NJ FamilyCare. The Health Plan selected only applies if the Applicant(s) is eligible for NJ FamilyCare. If the Applicant(s) needs assistance selecting the Applicant(s) Health Plan, contact a Health Benefits Coordinator at 1-800-701-0710, TTY 1-800-701-0720.

Choose One:

- ☐ **Aetna Better Health® of New Jersey** (Available in Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset and Union counties ONLY)
- ☐ **Amerigroup New Jersey, Inc.** (Available in ALL counties; except Salem county)
- ☐ **Horizon NJ Health** (Available in ALL counties)
- ☐ **UnitedHealthcare Community Plan** (Available in ALL counties)
- ☐ **WellCare Health Plans of New Jersey** (Available in Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties ONLY)

I understand that if I'm found eligible and because I have joined a Health Plan, I must follow the rules for obtaining health care from the Health Plan. I understand that I must let my Health Plan and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my Health Plan. I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist. I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the Health Plan as soon as possible after I, or the family member, go to the hospital. I understand that I must keep any medical appointment I have scheduled with a doctor and, if I cannot, I must call the doctor's office to cancel the appointment. I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the Health Plan, I may have to pay for that doctor's services because NJ FamilyCare will not pay for the unapproved service or visit. I understand that I may change to another Health Plan and that I can call the Health Benefits Coordinator to help me do that. I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the Health Plan and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the Health Plan.

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SECTION 12 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**
- 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;

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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.
- 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.

SIGN ON BACK

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Date Applied _____

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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 13 Signature

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'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 _____

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PRINT, SIGN and SEND to your LOCAL COUNTY WELFARE AGENCY at the appropriate address listed below.

NEW JERSEY COUNTY WELFARE AGENCIES

ATLANTIC COUNTY DIVISION OF INTERGENERATIONAL SERVICES - ABD MEDICAID 101 SOUTH SHORE RD NORTHFIELD, NJ 08225 609-645-7700	**MIDDLESEX** COUNTY BOARD OF SOCIAL SERVICES 181 HOW LANE, P.O. BOX 509 NEW BRUNSWICK, NJ 08903 732-745-3500
BERGEN COUNTY BOARD OF SOCIAL SERVICES 218 ROUTE 17 NORTH ROCHELLE PARK, NJ 07662-3300 201-368-4200	**MONMOUTH** COUNTY DIVISION OF SOCIAL SERVICES 3000 KOZLOSKI RD., P.O. BOX 3000 FREEHOLD, NJ 07728 732-431-6000
BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD. MOUNT HOLLY, NJ 08060-3335 609-261-1000	**MORRIS** COUNTY OFFICE OF TEMPORARY ASSISTANCE 340 W. HANOVER, P.O. BOX 900 MORRISTOWN, NJ 07963-0900 973-326-7800
CAMDEN COUNTY BOARD OF SOCIAL SERVICES ALETHA R. WRIGHT ADMINISTRATION BLDG. 600 MARKET ST. CAMDEN, NJ 08102-1255 856-225-8800	**OCEAN** COUNTY BOARD OF SOCIAL SERVICES 1027 HOOPER AVE., P.O. BOX 547 TOMS RIVER, NJ 08754-0547 732-349-1500
CAPE MAY COUNTY BOARD OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 4005 ROUTE 9 SOUTH RIO GRANDE, NJ 08242-1911 609-886-6200	**PASSAIC** COUNTY BOARD OF SOCIAL SERVICES 80 HAMILTON ST. PATERSON, NJ 07505-2057 973-881-0100
CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 275 NORTH DELSEA DR. VINELAND, NJ 08360-3607 856-691-4600	**SALEM** COUNTY BOARD OF SOCIAL SERVICES 147 S. VIRGINIA AVE. PENNS GROVE, NJ 08069-1797 856-299-7200
ESSEX COUNTY DEPARTMENT OF CITIZEN SERVICES DIVISION OF FAMILY ASSISTANCE & BENEFITS 18 RECTOR ST, 5TH FL. NEWARK, NJ 07102 973-733-3000	**SOMERSET** COUNTY BOARD OF SOCIAL SERVICES 73 E. HIGH ST., P.O. BOX 936 SOMERVILLE, NJ 08876-0936 908-526-8800
GLOUCESTER COUNTY DIVISION OF SOCIAL SERVICES 400 HOLLYDELL DR. SEWELL, NJ 08080 856-582-9200	**SUSSEX** COUNTY DIVISION OF SOCIAL SERVICES 83 SPRING ST., STE. 203. P. O. BOX 218 NEWTON, NJ 07860 973-383-3600
HUDSON COUNTY DEPARTMENT OF FAMILY SERVICES DIVISION OF WELFARE 257 CORNELISON AVENUE JERSEY CITY, NJ 07306 201-420-3000	**UNION** COUNTY DIVISION OF SOCIAL SERVICES 342 WESTMINSTER AVE. ELIZABETH, NJ 07208-3290 908-965-2700
HUNTERDON COUNTY DEPT OF HUMAN SERVICES DIVISION OF SOCIAL SERVICES P.O. BOX 2900 FLEMINGTON, NJ 08822-2900 908-788-1300	**WARREN** COUNTY DIVISION OF TEMPORARY ASSISTANCE AND SOCIAL SERVICES 1 SHOTWELL DRIVE BELVIDERE, NJ 07823 908-475-6301
MERCER COUNTY BOARD OF SOCIAL SERVICES 200 WOOLVERTON ST., P.O. BOX 1450 TRENTON, NJ 08650-2099 609-989-4320	

SUPPLEMENTAL INFORMATION

Designation of Authorized Representative Form

NJ FAMILYCARE
Affordable health coverage. Quality care.

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

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

I, _____ hereby authorize the following person or company to be
(Name of Applicant)
my Authorized Representative in my application for Medicaid filed with the Eligibility Determining Agency (EDA) or New Jersey Division of Medical Assistance and Health Services (DMAHS) and in all review of my eligibility. I authorize my representative to take any action which may be necessary to establish my eligibility for NJ FamilyCare.

Name of Representative: _____

Company: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

_____ initial

My decision to appoint an Authorized Representative is voluntary and made freely. I understand that signing this document does not relieve me of my responsibility to participate in the NJ FamilyCare eligibility process, including providing information and documents.

_____ initial

I understand that as a result of this authorization, the DMAHS and the applicable EDA may disclose and release information to the Authorized Representative including my Social Security number, financial statements, medical information and the reasons for denial.

_____ initial

I have been fully informed in writing by the Authorized Representative of actual or potential conflicts of interests that may exist between the above named entity and me. I hereby waive any conflict of interest. If there is no conflict of interest, the Authorized Representative has also put that in writing.

_____ initial

I understand that the information shared with Authorized Representative may affect my liability to a third party, include the Authorized Representative and may be disclosed to others. I hereby hold DMAHS and the EDA harmless for any claim or action resulting from the use or disclosure of information by my Authorized Representative.

SIGN ON BACK

Signatures

_____ initial — I understand that I may revoke this authorization at any time by notifying the Authorized Representative and the EDA in writing.

_____ initial — I understand that while this authorization is in effect, all notices/correspondence sent by DMAHS and the applicable EDA will only be sent to the Authorized Representative.

_____ initial — I understand that neither the State of New Jersey nor the EDA charge a fee to file a NJ FamilyCare application.

_____ Signature of NJ FamilyCare Applicant or Person Granting Authority

_____ Date (mm/dd/yyyy)

_____ Relationship (Self, Guardian, etc.)

_____ Witness

_____ Date (mm/dd/yyyy)

_____ Print Name

_____ Signature of Authorized Representative

_____ Title (if employee of authorized company)

_____ Print Name

_____ Date (mm/dd/yyyy)

_____ Witness

_____ Date (mm/dd/yyyy)

_____ Print Name

This form has no effect unless witnessed and signed by the person granting authority and by the Authorized Representative or an agent of the company appointed to be the Authorized Representative.

NJFC-AUTH-0217

SUPPLEMENTAL INFORMATION

Spouse Information Form

NJFAMILYCARE
Affordable health coverage. Quality care.

NJ FamilyCare
Aged, Blind, Disabled Programs

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

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/yyy)

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
mm/dd/yyyy

SECTION 2 Demographic Information for the Applicant 2 (Spouse)

Date of Birth: _____ Sex: ☐ Male ☐ Female
mm/dd/yyyy

Citizenship Status: ☐ US Citizen ☐ Refugee ☐ Asylee ☐ Legal Alien _____
☐ Not Lawfully Admitted Date of Entry (mm/dd/yyyy)

Place of Birth: City _____ State _____ Country _____

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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

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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

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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**

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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 # _____

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.

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Date Applied _____

Registration # _____

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