# Application for Health Coverage & Help Paying Costs

**Use this application to see what coverage choices you qualify for**

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP), known as NJ FamilyCare
- Private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can help pay your premiums for health coverage

**Who can use this application?**

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit [njfamilycare.org](http://njfamilycare.org).
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

**Apply faster online**

Apply faster online at [njfamilycare.org](http://njfamilycare.org).

**What you may need to apply**

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

**Why do we ask for this information?**

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to [njfamilycare.org](http://njfamilycare.org).

**What happens next?**

Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit [njfamilycare.org](http://njfamilycare.org) or call 1-800-701-0710. Filling out this application doesn't mean you have to buy health coverage.

**Get help with this application**

- **Online:** [njfamilycare.org](http://njfamilycare.org)
- **Phone:** Call our Help Center at 1-800-701-0710.
- **In person:** There may be counselors in your area who can help. Visit our website or call 1-800-701-0710 for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al 1-800-701-0710.
**STEP 1  Tell us about yourself.**

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.)

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. County

8. Current mailing address (if different from home address)

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. County

14. Phone number

   (________) –

15. Other phone number

   (________) –

16. Do you want to get information about this application by email?  ☐ Yes  ☐ No

   Email address: ____________________________________________

17. What is your preferred spoken or written language (if not English)?

**STEP 2  Tell us about your family.**

**Family Planning (Plan First Program)**

If any person on this application is not eligible for NJ FamilyCare, would you like them to be evaluated for family planning services (Plan First Program)?

☐ Yes  ☐ Check here for all applicants on this application to be evaluated for family planning services.

*Plan First is a program for women and men that provides only family planning and related services (such as birth control and reproductive health care). Family planning services do not provide minimum essential health care coverage (such as routine care).*

**Who do you need to include on this application?**

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

**DO Include:**

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

**You DON'T have to include:**

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

**Complete Step 2 for each person in your family.** Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

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).
**STEP 2: PERSON 1**  (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don’t file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?  
   SELF

3. Date of birth (mm/dd/yyyy)

4. Citizenship Status:  
   - US Citizen
   - Refugee
   - Asylee
   - Not Lawfully Admitted
   Legal Alien
   USCIS/Alien # ____________________________
   Date of Entry ____________
   Official Name on Immigration Document/Card (AKA) ____________________________
   Immigration Card # ____________________________

5. Sex  
   - Male
   - Female
   Official Name on Immigration Document/Card (AKA) ____________________________

6. Social Security number (SSN) __ _______ - _______ - _______  
   We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don’t want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who’s eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

   **7a. Check this box if you plan to file a federal income tax return NEXT YEAR.**  
   (You can still apply for health insurance even if you don’t file a federal income tax return.)
   - Will you file jointly with your spouse?  
     - Yes
     - No
   - If yes, name of spouse: ____________________________________________
   - Will you claim any dependents on your tax return?  
     - Yes
     - No
   - If yes, list name(s) of dependents: ____________________________________________

   **7b. Check this box if you will be claimed as a dependent on someone’s federal tax return.**
   - If yes, please list the name of the tax filer: ____________________________
   - How are you related to the tax filer? ____________________________

8. Are you pregnant?  
   - Yes
   - No  
   a. If yes, how many babies are expected during this pregnancy? ________  
      Due Date ____________

9. **Do you need health coverage?**  
   (Even if you have insurance, there might be a program with better coverage or lower costs.)
   - YES. If yes, answer all the questions below.
   - NO. If no, SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?  
    - Yes
    - No

11. Do you want help paying for medical bills from the last 3 months?  
    - Yes
    - No

12. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?  
    - Yes
    - No

13. Are you a full-time student?  
    - Yes
    - No

14. Were you in foster care at age 18 or older?  
    - Yes
    - No

15. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
    - Mexican
    - Mexican American
    - Chicano/a
    - Puerto Rican
    - Cuban
    - Other ____________________________

16. **Race (OPTIONAL—check all that apply.)**
    - White
    - Black or African American
    - Native American Indian or Alaska Native
    - Asian Indian
    - Chinese
    - Filipino
    - Japanese
    - Korean
    - Native Hawaiian
    - Vietnamese
    - Guamanian or Chamorro
    - Samoan
    - Other Pacific Islander
    - Other ____________________________

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).
STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ Employed
If you’re currently employed, tell us about your income. Start with question 17.

☐ Not employed
Skip to question 27.

☐ Self-employed
Skip to question 26.

CURRENT JOB 1:

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

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

21. Employer name and address

22. Employer phone number

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

$ ______________________

24. Average hours worked each WEEK

25. In the past year, did you:  ☐ Change jobs  ☐ Stop working  ☐ Start working fewer hours  ☐ None of these

26. If self-employed, answer the following questions:
   a. Type of work
   b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

   __________________________________________

   $ ______________________

27. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

   NOTE: You don’t need to tell us about child support, veteran’s payment, or Supplemental Security Income (SSI).

   ☐ None

   ☐ Unemployment  $ ______ How often? ________

   ☐ Pensions  $ ______ How often? ________

   ☐ Social Security  $ ______ How often? ________

   ☐ Retirement accounts  $ ______ How often? ________

   ☐ Alimony received  $ ______ How often? ________

   ☐ Net farming/fishing  $ ______ How often? ________

   ☐ Net rental/royalty  $ ______ How often? ________

   ☐ Other income  $ ______ How often? ________

Type: ______________________

28. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

   If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

   NOTE: You shouldn’t include a cost that you already considered in your answer to net self-employment (question 27b).

   ☐ Alimony paid  $ ______ How often? ________

   ☐ Student loan interest  $ ______ How often? ________

   ☐ Other deductions  $ ______ How often? ________

Type: ______________________

29. 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 person.

Your total income this year

$ ______________________

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

$ ______________________

THANKS! This is all we need to know about you.
**STEP 2: PERSON 2**

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix
2. Relationship to you?

3. Date of birth (mm/dd/yyyy)
   Legal Alien ☐ USCIS/Alien # ☐ Immigration Card #

5. Sex ☐ Male ☐ Female
   Official Name on Immigration Document/Card (AKA)
   Date of Entry

6. Social Security number (SSN) __ __ __ - __ __ __ - __ __ __ __
   We need this if you want health coverage and have an SSN.

7. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
   If no, list address: ____________________________

8a. ☐ Check this box if PERSON 2 plans to file a federal income tax return NEXT YEAR.
    (You can still apply for health insurance even if you don’t file a federal income tax return.)
    Will PERSON 2 file jointly with their spouse? ☐ Yes ☐ No
    If yes, name of spouse: ____________________________

8b. ☐ Check this box if PERSON 2 plans to be claimed as a dependent on someone’s federal tax return.
    If yes, please list the name of the tax filer: ____________________________
    How is PERSON 2 related to the tax filer? ____________________________

9. Is PERSON 2 pregnant? ☐ Yes ☐ No
   a. If yes, how many babies are expected during this pregnancy? _________
   b. Due Date ____________________________

10. Does PERSON 2 need health coverage?
    (Even if they have insurance, there might be a program with better coverage or lower costs.)
    ☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions on page 5.
    Leave the rest of this page blank.

11. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

12. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

15. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
   a. If yes, end date: ____________________________
   b. Reason the insurance ended: ____________________________

16. Is PERSON 2 a full-time student? ☐ Yes ☐ No

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____________________________

18. Race (OPTIONAL—check all that apply.)
    ☐ White ☐ Black or African American ☐ Native American Indian or Alaska Native
    ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
    ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
    ☐ Guamanian or Chamarro ☐ Samoan ☐ Other Pacific Islander
    ☐ Other ____________________________

Now, tell us about any income from PERSON 2 ➜

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).
### Current Job & Income Information

**Employed**
- If you're currently employed, tell us about your income. Start with question 19.

**Not employed**
- Skip to question 29.

**Self-employed**
- Skip to question 28.

#### CURRENT JOB 1:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer name and address</td>
<td></td>
</tr>
<tr>
<td>Employer phone number</td>
<td>(      ) –</td>
</tr>
<tr>
<td>Wages/tips (before taxes)</td>
<td>$</td>
</tr>
<tr>
<td>Hours: Hourly, Weekly, Every 2 weeks, Twice a month, Monthly, Yearly</td>
<td></td>
</tr>
<tr>
<td>Average hours worked each WEEK</td>
<td></td>
</tr>
</tbody>
</table>

#### CURRENT JOB 2:

(If you have more jobs and need more space, attach another sheet of paper.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer name and address</td>
<td></td>
</tr>
<tr>
<td>Employer phone number</td>
<td>(      ) –</td>
</tr>
<tr>
<td>Wages/tips (before taxes)</td>
<td>$</td>
</tr>
<tr>
<td>Hours: Hourly, Weekly, Every 2 weeks, Twice a month, Monthly, Yearly</td>
<td></td>
</tr>
<tr>
<td>Average hours worked each WEEK</td>
<td></td>
</tr>
</tbody>
</table>

#### In the past year, did PERSON 2:
- Change jobs
- Stop working
- Start working fewer hours
- None of these

#### If self-employed, answer the following questions:

- a. Type of work
- b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ __________________________

#### OTHER INCOME THIS MONTH:

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

- None
- Unemployment: $ _____ How often? ________
- Pensions: $ _____ How often? ________
- Social Security: $ _____ How often? ________
- Retirement accounts: $ _____ How often? ________
- Alimony received: $ _____ How often? ________
- Net farming/fishing: $ _____ How often? ________
- Net rental/royalty: $ _____ How often? ________
- Other income: $ _____ How often? ________

#### DEDUCTIONS:

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

- Alimony paid: $ _____ How often? ________
- Student loan interest: $ _____ How often? ________
- Other deductions: $ _____ How often? ________

#### YEARLY INCOME:

Complete only if PERSON 2’s income changes from month to month.

If you don’t expect changes to PERSON 2’s monthly income, add another person or skip to the next section.

<table>
<thead>
<tr>
<th>PERSON 2’s total income this year</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSON 2’s total income next year (if you think it will be different)</td>
<td>$</td>
</tr>
</tbody>
</table>

**THANKS! This is all we need to know about PERSON 2.**
STEP 3 Native American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family Native American Indian or Alaska Native?
   - [ ] If No, skip to Step 4.
   - [ ] Yes. If yes, go to Appendix B.

STEP 4 Your Family’s Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?
   - [ ] YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.
   - [ ] NO.

   - Medicaid _____________________________
   - NJ FamilyCare _____________________________
   - Medicare _____________________________
   - TRICARE (Don't check if you have direct care or Line of Duty) _____________________________
   - VA health care programs _____________________________
   - Peace Corps _____________________________
   - Plan First (Family Planning) _____________________________
   - Employer insurance _____________________________

   - Name of health insurance: _____________________________
   - Policy number: _____________________________
   - Is this COBRA coverage? [ ] Yes [ ] No
   - Is this a retiree health plan? [ ] Yes [ ] No
   - Other _____________________________

   - Name of health insurance: _____________________________
   - Policy number: _____________________________
   - Is this a limited-benefit plan (like a school accident policy)? [ ] Yes [ ] No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.
   - [ ] YES. If yes, you'll need to have your employer complete Appendix A and return to address provided.
   - [ ] NO. If no, continue to Step 5.

STEP 5 Select your Health Plan

If you need assistance selecting your 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 ALL counties)
   - [ ] Amerigroup New Jersey, Inc. (Available in ALL counties)
   - [ ] Horizon NJ Health (Available in ALL counties)
   - [ ] UnitedHealthcare Community Plan (Available in ALL counties)
   - [ ] WellCare Health Plans of New Jersey (Available in ALL counties, except Hunterdon county)

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.

FOR OFFICE USE ONLY
Name __________________________________________ Case # __________________________________________
STEP 6  Read & sign this application.

- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if Federal privacy law requires or allows it, or if State law requires it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support.
- 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 that I must tell NJ FamilyCare immediately about any changes in my information, such as a change in income, address, family size, if someone in my household is expecting a baby, or if anyone in my household who applied for NJ FamilyCare gets other health insurance. I understand that a change in my information could affect the eligibility for member(s) of my household. I know that I must call 1-800-701-0710 (TTY 1-800-701-0720) to report any changes.
- I authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare.
- I also authorize any educational institution or school district to release my medical records or those of my child(ren) to the NJ FamilyCare program for the purpose of determining eligibility and billing the Program.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We’ll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, NJ Division of Taxation, and/or a consumer reporting agency. If the information doesn’t match, we may ask you to send us proof.

Renewal of coverage in future years
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow NJ FamilyCare to use income data, including information from tax returns. NJ FamilyCare will send me a notice, let me make any changes, and I can opt out at any time.

If anyone on this application is eligible for NJ FamilyCare
- I am giving to the NJ FamilyCare agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the NJ FamilyCare agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home?  □ Yes  □ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell NJ FamilyCare and I may not have to cooperate.

My right to appeal
If I think NJ FamilyCare has made a mistake, I can appeal its decision. To appeal means to tell someone at NJ FamilyCare that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting NJ FamilyCare at 1-800-701-0710. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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/customers/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf

Sign this application. The person who filled out Step 1 should sign this application. If you’re an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature Date (mm/dd/yyyy)

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.

STEP 7  Mail Completed Application.

Mail your signed application to:

NJ FamilyCare
PO BOX 8367
TRENTON, NJ  08650-9802

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).
## Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

*You need to include this page when you send in your application.*

### EMPLOYEE Information

1. Employee name (First, Middle, Last)  
2. Employee Social Security number

### EMPLOYER Information

3. Employer name  
4. Employer Identification Number (EIN)  
5. Employer address  
6. Employer phone number  
7. City  
8. State  
9. ZIP code  

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)  
12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?  
   • Yes (Continue)  
   13a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)
   List the names of anyone else who is eligible for coverage from this job.
   
   Name: ____________________________  Name: ____________________________  Name: ____________________________

   • No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?  
   • Yes  
   • No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

   a. How much would the employee have to pay in premiums for this plan? $ ____________
   b. How often?  
      • Weekly  
      • Every 2 weeks  
      • Twice a month  
      • Quarterly  
      • Yearly

16. What change will the employer make for the new plan year (if known)?  
   • Employer won't offer health coverage  
   • Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much will the employee have to pay in premiums for that plan? $ ____________
   b. How often?  
      • Weekly  
      • Every 2 weeks  
      • Twice a month  
      • Quarterly  
      • Yearly

   Date of change (mm/dd/yyyy): ____________________________

* An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**NEED HELP WITH YOUR APPLICATION?** Visit njfamilycare.org or call us at 1-800-701-0710. Para obtener una copia de este formulario en Español, llame 1-800-701-0710. If you need help in a language other than English, call 1-800-701-0710 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-800-701-0720.
**APPENDIX B**

**Native American Indian or Alaska Native Family Member (AI/AN)**

Complete this appendix if you or a family member are Native American Indian or Alaska Native. Submit this with your NJ FamilyCare Application for Health Coverage & Help Paying Costs.

**Tell us about your Native American Indian or Alaska Native family member(s).**

Native American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

**NOTE:** If you have more people to include, make a copy of this page and attach.

<table>
<thead>
<tr>
<th>AI/AN PERSON 1</th>
<th>AI/AN PERSON 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name</td>
<td></td>
</tr>
<tr>
<td>(First name, Middle name, Last name)</td>
<td>(First name, Middle name, Last name)</td>
</tr>
<tr>
<td>First</td>
<td>Middle</td>
</tr>
<tr>
<td>Last</td>
<td>Last</td>
</tr>
</tbody>
</table>

2. Member of a federally recognized tribe?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

4. Certain money received may not be counted for NJ FamilyCare. List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

<table>
<thead>
<tr>
<th>$ ______________</th>
<th>$ ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often?</td>
<td>How often?</td>
</tr>
</tbody>
</table>

**NEED HELP WITH YOUR APPLICATION?** Visit njfamilycare.org or call us at 1-800-701-0710. Para obtener una copia de este formulario en Español, llame 1-800-701-0710. If you need help in a language other than English, call 1-800-701-0710 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-800-701-0720.
## Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact NJ FamilyCare. If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)
2. Address
3. Apartment or suite number
4. City
5. State
6. ZIP code
7. Phone number
   (    )        –
8. Organization name
9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature
11. Date (mm/dd/yyyy)

---

### For certified application counselors, navigators, agents, and brokers only.

Complete this section if you’re a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
2. First name, Middle name, Last name, & Suffix
3. Organization name
4. ID number (if applicable)
Non-Discrimination Statement

Discrimination is Against the Law

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. NJ FamilyCare does not exclude people or treat them differently because of race, color, national origin, sex, age or disability.

NJ FamilyCare:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, please contact 1-800-701-0710 (TTY: 1-800-701-0720).

If you believe that NJ FamilyCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age or disability, you can file a grievance with the NJ FamilyCare Civil Rights Coordinator via the following: NJ Civil Rights Coordinator, NJ Department of Human Services, Office of Legal and Regulatory Affairs, P.O. Box 700, Trenton, NJ 08625-0700, 1-888-347-5345 or email: DHS-CO.OLRA@dhs.state.nj.us. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also electronically file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
SW, Room 509F, HHH Building
200 Independence Avenue
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)


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).
New Jersey Non-Discrimination Statement

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).

Spanish. NJ FamilyCare cumple con las leyes federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, el sexo, la edad o la discapacidad. Si usted habla español, tiene a su disposición los servicios de asistencia con el idioma sin costo alguno. Llame al 1-800-701-0710 (TTY: 1-800-701-0720).

Chinese. NJ FamilyCare 遵守适用的联邦人权法律，不会因为种族、肤色、原国籍、性别、年龄或残疾而进行歧视。如果您讲中文，您可以免费获得语言协助服务。致电 1-800-701-0710 (TTY: 1-800-701-0720).


Gujarati. NJ FamilyCare, જાતીય પદતાલા કુકર નગરિક અસમાનતા કારણેણ પાલન કરે છે ચાલુ, રંગ, રાશિશાલી સૂત્ર, લિંગ, વાણી વિશ્વાસના અને ભવના ભસ્તર કરતું નકારાત્મક. તે છે સુધી ઓછી ઓળખ પ્રદાન કરે છે સવિક્ષણસ્થિત સમાજ સાથે તમારી સહાયની નોકરી છે. કોઇ જ કોઇ 1-800-701-0710 (TTY: 1-800-701-0720).

Polish. NJ FamilyCare przestrzega wszelkich odnośnych przepisów federalnych dotyczących praw obywatelskich i nie dopuszcza się dyskryminacji z powodu ras, koloru skóry, pochodzenia narodowego, płci, pochodzenia, wieku lub niepełnosprawności. Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Proszę zadzwonić pod numer 1-800-701-0710 (TTY: 1-800-701-0720).

Italian. NJ FamilyCare si attiene a tutte le leggi federali per i diritti civili e non discrimina sulla base di etnia, colore, nazionalità, genere, età o disabilità. Se lei parla Italiano, sono a sua disposizione servizi gratuiti nella sua lingua. Chiami il numero 1-800-701-0710 (TTY: 1-800-701-0720).
Voter Registration Opportunity

The National Voter Registration Act of 1993 requires the State to provide you with the opportunity to register to vote as an additional service offered by this office. Please complete the form below to advise the agent of your interest to register or not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you decline to register to vote at this time, your decision will remain confidential and will be used only for voter registration purposes. If you do register to vote, the way in which you do so will remain confidential and will be used only for voter registration purposes.

You can register to vote if:

- You are a United States citizen
- You will be 18 years of age by the next election
- 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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: the NJ Division of Elections, (mailing address) P.O. Box 304, Trenton, NJ 08625-0304; (office location) 225 West State Street, 5th Floor, Trenton, NJ 08608; telephone 609-292-3760, fax number 609-777-1280, TTY 1-800-292-0034, Elections.NJ.gov.

If you would like help in filling out the voter registration application form, we will help you. You can call NJ FamilyCare at 1-800-356-1561. The decision whether to seek or accept help is yours. You may fill out the application form in private.

This section can be returned to NJ FamilyCare at: NVRA Liaison, PO 712, Trenton, NJ 08625-0712

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes    ☐ No    ☐ I am already registered

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

________________________  __________________________  __________________________
Print Name                    Signature                      Date

For Official Use

RTS ☐

_____ Initial
# New Jersey Voter Registration Application

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Check boxes □ New Registration □ Address Change □ Signature Update or Non-affiliation Change</td>
</tr>
<tr>
<td>2</td>
<td>Are you a U.S. Citizen? □ Yes □ No (If No, DO NOT complete this form)</td>
</tr>
<tr>
<td>3</td>
<td>Last Name</td>
</tr>
<tr>
<td>4</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>5</td>
<td>NJ Driver’s License Number or MVC Non-driver ID Number</td>
</tr>
<tr>
<td>6</td>
<td>Home Address (DO NOT use PO Box)</td>
</tr>
<tr>
<td>7</td>
<td>Mailing Address if different from above</td>
</tr>
<tr>
<td>8</td>
<td>Last Address Registered to Vote (DO NOT use PO Box)</td>
</tr>
<tr>
<td>9</td>
<td>Former Name if Making Name Change</td>
</tr>
<tr>
<td>10</td>
<td>Do you wish to declare a political party affiliation? □ Yes, the party name is __________________________.</td>
</tr>
<tr>
<td>11</td>
<td>Gender □ Female □ Male</td>
</tr>
</tbody>
</table>

**Signature:** Sign or mark and date on lines below

**If applicant is unable to complete this form, print the name and address of individual who completed this form.**

**X** ___________ ___________ Date ___________ ___________

**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
- □ polling place accessibility
- □ becoming a poll worker
- □ voting if you have a disability, including visual impairment
- □ available election materials in this alternative language:

For further information visit [Elections.NJ.gov](https://Elections.NJ.gov) or call toll-free [1-877-NJVOTER](tel:1-877-658-6837) (1-877-658-6837)

NJ Division of Elections - 02/16/16
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)

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