

1. Household Information

Home Address: _____ Apt. #/Floor: _____ Home Phone: _____ Cell Phone: _____ Other Phone: _____

City: _____ County: _____ State: _____ Zip: _____ Language spoken at home: _____

Mailing Address, if different: _____ City: _____ State: _____ Zip: _____ E-mail Address: _____

List ALL Parents/Guardians and Children UNDER THE AGE OF 21 Living in Your Household (If you need to write about more children, use another piece of paper)

Parent/Guardian First Name	Last Name	Sex M/F	Birth Date MM/DD/YYYY	Full-time Student?	Other health insurance now? (see instructions)	Other health insurance within the past 3 months? (see instructions)	Parent/Guardian Marital Status					Do you want NJ FamilyCare?*	Social Security Number	US Citizen? (See Instructions)	Qualified Immigrant? Date of Entry (See Instructions)	Race/Ethnicity**	
							Single	Married	Separated	Divorce	Widow/er						
			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Entry / /	
			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Entry / /	

** Race/Ethnicity Codes: B-Black S-Hispanic W-White I-Native American Indian/Alaska Native A-Asian/Pacific Islander O-Other * If NO, additional information for this person is not required.

Children First Name	Last Name						How is this child related to the 1st parent/guardian listed above?	How is this child related to the 2nd parent/guardian listed above?						
			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Entry / /	
			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Entry / /	
			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Entry / /	
			/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Entry / /	

► Is anyone listed above pregnant? Yes No If yes, please write the name (s) and due date (s): _____ Does anyone have unpaid medical bills for the last 3 months? Yes No If yes, please write name(s), see instructions: _____

2. Income Information for Parents/Guardians and Children under 21: see instructions.

Name of person receiving income, including children ■ Proof is required, see Instructions	Is this person Self-Employed?	Is this person a Business Owner?	Employer or Business Name	Employer or Business Phone Number	Date Business or Job Started	Full-time or Part-time?		How often paid?				Work income before taxes per pay period Amount	Other income such as child support, alimony, cash support, social security benefits, unemployment, rental income, etc.		If this person PAYS for day care for a child or disabled adult, list monthly amount	If this person PAYS child support or alimony, list monthly amount
						FT	PT	Every Week	Every 2 Weeks	2 Times a Month	Once a Month		Indicate Type of Income	Monthly Amount		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$

► Do any of the employers listed above offer health insurance? Yes No If yes, please list the Employer Name: _____ Employer address: _____

► Has anyone listed changed jobs in the last six months? Yes No If yes, please list Name _____ Former employer: _____ Date job ended: _____

3. Health Maintenance Organization (HMO) Information: You will have to pick an HMO to be enrolled. If you need assistance selecting your HMO, contact a Health Benefits Coordinator at 1-866-472-5338.

Select an HMO from the choice below:

AMERIGROUP Available in ALL counties; except Salem County

Healthfirst NJ Available in Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties ONLY

Horizon NJ Health Available in ALL counties

UnitedHealthcare Available in ALL counties

Who is your Doctor/Name & Address: _____

Your child's Doctor/Name & Address: _____

Is anyone applying taking prescription medicines; and/or using any special medical equipment; and/or receiving any medical treatment? Yes No

Chris Christie
Governor

Kim Guadagno
Lt. Governor

State of New Jersey

For Official Use Only

Enrollment Site#: _____

Policy #: _____

By signing this form, I represent that I have read and understood the Privacy Notice and the NJ FamilyCare program "Rights and Responsibilities", which I can also get at the NJ FamilyCare website at www.njfamilycare.org or by calling 1-800-701-0710, and that I will obey the law and regulations of the program. 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 also authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare. In addition, I hereby authorize any educational institutions 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. I certify under penalty of law that everything I have stated in this application is true. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment.

 Sign your name here: _____ Date: _____