NJ FAMILYCARE
Affordable health coverage. Quality care.

www.njfamilycare.org NJ FamilyCare / P.O. Box 8367 / Trenton, NJ 08650 **1-800-701-0710** (TTY 1-800-701-0720) **WE SPEAK 150 LANGUAGES**

NJ FamilyCare does not discriminate against anyone because of race, age, color, religion, sex, national origin, marital status, disability or political belief.

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: Single	Married	Separated	Divorce	Widow/er	Do you want NJ FamilyCare?*	Social Security Number	US Citizen? (See Instructions)	Qualified Immigrant? Date of Entry (See Instructions)	Race/ Ethnicity**
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑	❑	❑	❑		❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑No Date of Entry / /	
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑	❑	❑	❑		❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑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	Sex M/F	Birth Date	Full-time Student?	Other health insurance now?	Other health insurance within the past 3 months?	How is this child related to the 1st parent/guardian listed above?	How is this child related to the 2nd parent/guardian listed above?	Do you want NJ FamilyCare?*	Social Security Number	US Citizen?	Qualified Immigrant? Date of Entry	Race/ Ethnicity
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other	❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑No Date of Entry / /	
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other	❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑No Date of Entry / /	
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other	❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑No Date of Entry / /	
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other	❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑No Date of Entry / /	
			/ /	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Child ❑Stepchild ❑Other	❑Child ❑Stepchild ❑Other	❑Yes ❑No	- -	❑Yes ❑No	❑Yes ❑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? FT	PT	How often paid? Every Week	Every 2 Weeks	2 Times a Month	Once a Month	Work income before taxes per pay period: Amount	Other income such as child support, alimony, cash support, social security benefits, unemployment, rental income, etc.: Indicate Type of Income	Monthly Amount	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
	❑Yes ❑No	❑Yes ❑No				❑	❑	❑	❑	❑	❑	$		$	$	$
	❑Yes ❑No	❑Yes ❑No				❑	❑	❑	❑	❑	❑	$		$	$	$
	❑Yes ❑No	❑Yes ❑No				❑	❑	❑	❑	❑	❑	$		$	$	$

► 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	❑ Healthfirst NJ	❑ Horizon NJ Health	❑ UnitedHealthcare
Available in ALL counties; except Salem County	Available in Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties ONLY	Available in ALL counties	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: ____________

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