

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: _____

List ALL Parents/Guardians and Children UNDER THE AGE OF 21 Living in Your Household

Parent/Guardian First Name	Last Name	Do you want NJ FamilyCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex M/F	Social Security Number (Required for those applying)	Race/Ethnicity (only for those applying) **See codes below	Birth Date MM/DD/YYYY	US Citizen? (See instructions)	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	Divorced	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"/> 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	<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"/>

Are your children currently enrolled in NJ FamilyCare? Yes No If yes, what is the NJ FamilyCare policy number: _____

Children First Name	Last Name	Do you want NJ FamilyCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex M/F	Social Security Number (Required for those applying)	Race/Ethnicity (only for those applying) **See codes below	Birth Date MM/DD/YYYY	US Citizen? (See instructions)	Full-time Student?	Other health insurance now? (see instructions)	Other health insurance within the past 3 months? (see instructions)	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"/> 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	<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	<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	<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	<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

If you need to write about more children, use another piece of paper ** Race/Ethnicity Codes: B-Black S-Hispanic W-White I-Native American Indian/Alaska Native A-Asian/Pacific Islander O-Other
 ▶ Is anyone listed above pregnant? Yes No If yes, write 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	Employer Name ■ If self-employed write "self-employed"; or ■ If owner, write "owner"	Employer telephone number	Date 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$
				<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. HMO SELECTION: You must pick an HMO to be enrolled. Please see HMO flyer for available HMOs.

Choose an HMO: _____ Who is your doctor? _____ Address: _____
 Who is your child's doctor? _____ Address: _____
 Is anyone applying: Taking prescription medicines? Yes No Receiving any medical treatment? Yes No Using any special medical equipment? Yes No

Jon S. Corzine
Governor
State of New Jersey

By signing this form, I represent that I have read and understood the Privacy Notice and the NJ FamilyCare program "Rights and Responsibilities", and that I will obey the law and regulations of the program. I understand that I am giving the NJ FamilyCare program permission to release my medical records and those of any of my family members who enroll in the program, to the program's HMOs and its providers. I also authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare program. 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 on this application is true.

Sign your name here: _____ Date: _____

For Official Use Only
 Enrollment Site#: _____
 Policy #: _____