

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. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?			

STEP 2 Tell us about your family.

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.



NEED HELP WITH YOUR APPLICATION? Call us at **609-989-4320**. Para obtener una copia de este formulario en Español, llame **609-989-4320**.

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. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

5. 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.

6. Do 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.)

YES. If yes, please answer questions a-c. **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? Yes No a. **If yes,** how many babies are expected during this pregnancy? _____ Due Date _____

8. 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.

9. 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

10. Are you a U.S. citizen or U.S. national? Yes No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? Yes No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

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

13. 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

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

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

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

17. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> Native American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
				<input type="checkbox"/> Other _____



NEED HELP WITH YOUR APPLICATION? Call us at **609-989-4320** Para obtener una copia de este formulario en Español, llame **609-989-4320**.

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 18.
- Not employed**
Skip to question 28.
- Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address	19. Employer phone number () -
20. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
21. Average hours worked each WEEK	

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

22. Employer name and address	23. Employer phone number () -
24. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
25. Average hours worked each WEEK	

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

27. 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?
\$ _____

28. 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).

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Unemployment \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions \$ _____ How often? _____ | <input type="checkbox"/> Other income \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security \$ _____ How often? _____ | Type: _____ |
| <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ | |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | |

29. 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).

- | | |
|--|---|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Other deductions \$ _____ How often? _____ |
| <input type="checkbox"/> Student loan interest \$ _____ How often? _____ | Type: _____ |

30. 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) _____	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
-------------------------------------	--

5. Social Security number (SSN) _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? Yes No
If no, list address: _____

7. **Does PERSON 2 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.)

YES. If yes, please answer questions a-c. **NO. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? Yes No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? Yes No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No
If yes, please list the name of the tax filer: _____
 How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? Yes No a. **If yes**, how many babies are expected during this pregnancy? _____ Due Date _____

9. **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.

10. 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

11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? Yes No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? Yes No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Was PERSON 2 in foster care at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	---

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

16. 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: _____

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

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. **Race (OPTIONAL—check all that apply.)**

<input type="checkbox"/> White	<input type="checkbox"/> Native American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

Now, tell us about any income from PERSON 2

NEED HELP WITH YOUR APPLICATION? Call us at **609-989-4320**. Para obtener una copia de este formulario en Español, llame **609-989-4320**.

STEP 2: PERSON 2

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 20.

Not employed

Skip to question 30.

Self-employed

Skip to question 29.

CURRENT JOB 1:

20. Employer name and address	21. Employer phone number () -
-------------------------------	------------------------------------

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

23. Average hours worked each WEEK

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

24. Employer name and address	25. Employer phone number () -
-------------------------------	------------------------------------

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

27. Average hours worked each WEEK

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

29. 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?

\$ _____

30. 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).

<input type="checkbox"/> None		<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____	
<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Net rental/royalty	\$ _____	How often? _____
<input type="checkbox"/> Pensions	\$ _____	How often? _____	<input type="checkbox"/> Other income	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	Type: _____		
<input type="checkbox"/> Retirement accounts	\$ _____	How often? _____			
<input type="checkbox"/> Alimony received	\$ _____	How often? _____			

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

If PERSON 2 pays 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 29b).

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____	<input type="checkbox"/> Other deductions	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____	Type: _____		

32. 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.

PERSON 2's total income this year \$ _____	PERSON 2's total income next year (if you think it will be different) \$ _____
--	--

THANKS! This is all we need to know about PERSON 2.



NEED HELP WITH YOUR APPLICATION? Call us at **609-989-4320**. Para obtener una copia de este formulario en Español, llame **609-989-4320**.

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.**
- | | |
|--|---|
| <input type="checkbox"/> Medicaid _____ | <input type="checkbox"/> Employer insurance _____ |
| <input type="checkbox"/> NJ FamilyCare _____ | Name of health insurance: _____ |
| <input type="checkbox"/> Medicare _____ | Policy number: _____ |
| <input type="checkbox"/> TRICARE (Don't check if you have direct care or Line of Duty) _____ | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> VA health care programs _____ | <input type="checkbox"/> Other |
| <input type="checkbox"/> Peace Corps _____ | Name of health insurance: _____ |
| | Policy number: _____ |
| | Is this a limited-benefit plan (like a school accident policy)? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

- Aetna Better Health® of New Jersey** (Available in Bergen, Camden, Essex, Hudson, Middlesex, Passaic, Somerset & Union counties)
 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 & 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.



NEED HELP WITH YOUR APPLICATION? Call us at **609-989-4320**. Para obtener una copia de este formulario en Español, llame **609-989-4320**.

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 know that I must promptly tell NJ FamilyCare if anything changes or becomes different from what I wrote on this application including changes in income, address or household size. I can visit njfamilycare.org or call **1-800-701-0710** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- 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.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.

(name of person)

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

NJ FamilyCare Medicaid benefits received after the age of 55 may be reimbursable to the State of New Jersey from the member's estate. The recovery may include premium payments made on behalf of the beneficiary. 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

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)

STEP 7 Mail completed application.

Mail your signed application to:

Mercer County Board of Social Services
200 Woolverton St.
P.O. Box 1450
Trenton, New Jersey 08650-2099

If you are not registered to vote where you live now, would you like to apply to register to vote? Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this Agency.

For more information on the [Notice of Your Opportunity To Vote Rights](#) visit the link below:
<http://www.state.nj.us/state/elections/nvra-forms/nvra-opportunity-form-081810.pdf>

For more information on the [Voter Registration Application](#) visit the link below:
<http://www.state.nj.us/state/elections/voting-information-voter-registration-forms.html>
(Fill in the required information, *print as a two-sided document*, and fold to mail).

If you would like a Voter Registration Application mailed to you, **please check this box** .



NEED HELP WITH YOUR APPLICATION? Call us at 609-989-4320. Para obtener una copia de este formulario en Español, llame 609-989-4320.

APPENDIX A

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)



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.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
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: <ul style="list-style-type: none"> • 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 	\$ _____ How often? _____	\$ _____ How often? _____



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)

