

INSURANCE QUICK REFERENCE GUIDE



3/26/2019

Guidelines for Enrolling Clients in NJ FamilyCare

This project was developed by the Healthy Mothers, Healthy Babies Coalition of the Southern New Jersey Perinatal Cooperative in collaboration with Atlantic County Division of Public Health.



Southern New Jersey
**PERINATAL
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Insurance Quick Reference Guide

GUIDELINES FOR ENROLLING CLIENTS IN NJ FAMILYCARE

The purpose of this guide is to help healthcare workers better assist their clients with the NJ FamilyCare application process. Obtaining healthcare coverage is very important because it allows clients to gain access to the healthcare system. Those with health insurance coverage are more likely to receive care and experience better health outcomes than those who are uninsured. Many residents may be eligible for publically funded insurance coverage such as NJ FamilyCare but are not aware of their eligibility or the steps they need to take to apply. This guide will help healthcare workers better understand the application process and provide information about some of the common challenges individuals face when applying for insurance coverage through NJ FamilyCare.

This project was developed by the Healthy Mothers, Healthy Babies Coalition of the Southern New Jersey Perinatal Cooperative and the Atlantic County Division of Public Health. Most of the information provided in this guide was obtained from the NJ FamilyCare website (njfamilycare.org). This website provides a wealth of information about the NJ FamilyCare application process including eligibility requirements, immigrant information, how to apply, and how to choose a health plan. Individuals interested in applying for NJ FamilyCare can apply online at this website or use the paper application attached (found on the website) and return by mail.

This guide also includes information that healthcare workers can use to direct their clients to appropriate healthcare organizations for care while they wait for their insurance to become effective or if they need treatment but do not qualify for NJ FamilyCare. These organizations include Federally Qualified Health Centers and other medical facilities that offer services on a sliding scale for uninsured or underinsured residents.

Information about NJ FamilyCare in this guide was obtained from the following source:

State of New Jersey. (2013). NJFAMILYCARE. Retrieved from <http://www.njfamilycare.org>

Health Insurance Quick Reference Guide

1 Check Eligibility

NJ FamilyCare is publicly funded free or low-cost health insurance for NJ residents. NJ FamilyCare is for people who do not have employer insurance.

Eligibility Requirements

To be eligible for NJ FamilyCare, a person must be either:

- **An adult US citizen.**
- **A “legal permanent resident”** that has had status **for a least five years.**
- **A “qualified immigrant”** whose documents allow them to remain here permanently, **regardless of date of entry.**
 - “Qualified” status includes:
 - A lawful permanent resident
 - A refugee
 - An asylee
 - A Cuban-Haitian entrant
 - An undocumented resident whose deportation is being withheld by USCIS, immigrant paroled over one year
 - A child of an honorably discharged US military veteran
 - A child of a member of the US military
 - Amerasian immigrant
 - An applicant under Violence Against Women Act
 - Certain American Indians born in Canada
- **A pregnant woman.**
 - Pregnant women who are lawfully admitted can be eligible even if they have lived in this country fewer than five years.
- **A child who is 18 years of age or younger.**
 - “Qualified” children can be eligible even if they have lived in this country fewer than five years.

Income Eligibility

FAMILY SIZE*	Family		Pregnant		Foster Care	
	Individuals	Household	Individuals	Household	Individuals	Household
1	\$12,400	\$15,750	\$12,400	\$15,750	\$12,400	\$15,750
2	\$16,400	\$20,750	\$16,400	\$20,750	\$16,400	\$20,750
3	\$20,400	\$25,750	\$20,400	\$25,750	\$20,400	\$25,750
4	\$24,400	\$30,750	\$24,400	\$30,750	\$24,400	\$30,750
5	\$28,400	\$35,750	\$28,400	\$35,750	\$28,400	\$35,750
6	\$32,400	\$40,750	\$32,400	\$40,750	\$32,400	\$40,750

- Review the **NJ FamilyCare Income Chart** (Appendix A) to determine the client’s possible eligibility.
- Financial eligibility for individuals seeking eligibility for NJ FamilyCare will be based on the household **Modified Adjusted Gross Income** reported on the federal tax return. The income and household size will be determined by their latest federal tax return which when filed, can be electronically verified.
- The size of the family may be determined by the total number of parent(s), or caretaker(s), and all blood-related children under the age of 21 who are tax dependent, as well as any other tax dependents residing in the home.
- If eligible for NJ FamilyCare, individuals will receive comprehensive health insurance services which covers:
 - doctor visits, eyeglasses, hospitalization, lab tests, x-rays, prescriptions, mental health, dental, and preventative screenings.
- For many people, NJ FamilyCare will cost nothing: no monthly premiums or co-payments. For higher income families with children there is a sliding scale for co-payments and monthly premiums.

2 Apply Online

The online application is very easy to complete. Individuals can apply for themselves and children at one time. If a person is not eligible for coverage, they can still apply for their child. Families that include immigrants can also apply. For those who are immigrants, applying won't affect their immigration status or chances of becoming a permanent resident or citizen.

1. Go to njfamilycare.org

- To start an application, click “**Apply Here**” in the red star on the top right-hand corner of the home page.
- To create a new application, click “**Start New Application.**” To complete an existing application, click “**Resume Existing Application.**”

2. Fill out the application (Appendix B)

- Filling out the online application takes approximately 15-20 minutes.
- To fill out the online application, you will need the following information about your client's family before you begin. Family includes adoptive or natural parents and their spouses, or caretaker relatives if there are no parents, children under 21, and all claimed tax dependents:
 - Names and birthdates.
 - Social Security numbers or immigration numbers for those applying for coverage
 - Policy numbers for any current health insurance.
 - Employer and/or income information for the last 30 days for everyone in the family (for example, employer address and gross income.)
 - **Note: Client must provide an accurate physical address. A PO Box address will not be accepted.**
- Immigrant information:
 - To be eligible, immigrants must have documents that allow them to reside in the U.S. permanently.
 - Applying for NJ FamilyCare will not hurt their chances of becoming a legal permanent resident or US citizen.
 - Information provided to NJ FamilyCare is not shared with the U.S. Citizenship and Immigration Services.
 - A parent's immigration status does not need to be provided if the parent is not requesting health coverage for him or herself.
 - A parent's status has no effect on the eligibility of a child.
- In the application your client will need to select a health maintenance organization (HMO), or health coverage plan. When choosing a health plan, your clients should ask themselves:
 - What doctors or specialists do I/we see and what health plan do they participate in?
 - Does the health plan have other participating doctors, dentists, and drug stores that are convenient for me to use?

In Atlantic County, the health plan options may include:

 - Horizon Blue Cross and Blue Shield of New Jersey
 - United Healthcare
 - Amerigroup RealSolutions
 - Aetna Better Health of New Jersey
 - WellCare
- Answer all other questions and click “**Submit**” on the last page.
- You will receive a confirmation number. Print the confirmation page (Appendix C) for your client. If that is not accessible, write down the confirmation number and date applied and give to client.

3 Gather Documents

After applying online, NJFamilyCare will follow up in 2-4 weeks. Your client will receive a letter in the mail with instructions on the next steps to complete their application. The letter may request your client to send in documentation such as proof of citizenship, proof of income, or other documentation.

Listed below are the two main types of documentation that are usually needed. To speed up the application process, tell your clients to gather the documents listed below so they are ready if asked to send them in.

1. Proof of Citizenship

- Photocopy of Birth Certificate or
- Legal immigrant documents.
 - Examples of legal immigrant documents:
 - Permanent Resident Card (A.K.A -“Green Card”)
 - Employment Authorization Card or Work Permit
 - Foreign Passport or Form I-94 (arrival/departure record) with I-551 stamp.

2. Proof of Income

- Pay stub from current month of employment OR
- If unemployed, a written letter from self, stating you are unemployed OR
- If working under the table, a letter from self, stating your income.
- The Spanish Community Center offers assistance in writing letters that can be notarized for a \$15 fee. Their address is 3900 Ventnor Ave., Atlantic City, NJ 08401. Their number is 609-345-1249.

Common Issues

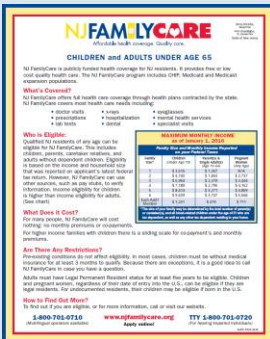


- When a pregnant woman receives Presumptive Eligibility (PE) at a certified PE provider in Atlantic County they will receive a **white Health Benefits Identification Card** in the mail (pictured on top left). This card allows them to receive temporary care, but it **does not mean they have been accepted to receive full insurance coverage for the year**. Tell your clients that they must check their mail for a letter with directions to follow to complete their health care coverage - **many people fail to receive coverage because do not check their mail and never send in the appropriate documentation**. See Appendix D for a sample letter.
- Your client will know that their application is complete and they have full coverage for the year when they receive another card in the mail from the Managed Care Organization they selected (e.g. – Horizon, Aetna, etc.; pictured on bottom left). Your client must bring this card in addition to the Health Benefits Identification Card to all doctor’s appointments.
- If someone moves after they apply for NJ Family Care, they may not receive the letter that was sent from NJ FamilyCare in the mail, and will not be informed of what they need to do to complete their application. Encourage clients to follow-up and check on the status of their application by contacting the numbers listed in the “Follow Up” (next section) of this document.
- If individuals who apply for NJ Family Care do not open their mail after they apply online, they may throw away the letter that details the next steps they need to take to complete their application, assuming it is junk mail. Tell your clients to open all mail they receive after the time they apply until they know they have taken the appropriate steps to complete their application.

4 Follow Up

Your client should hear back from NJ FamilyCare within 3-4 weeks. Instruct your client to contact the NJ FamilyCare number listed below if they have not heard back in that time frame. They can also call the Center For Family Services for help with their application or to have any questions answered about the NJ FamilyCare process.

1. NJ FamilyCare (Appendix B)



- Individuals can check the progress of their NJ FamilyCare application 24 hours a day, 7 days a week by calling **1-800-701-0710**.
 - If documents need to be sent by mail, send to:

NJ Family Care
PO Box 8367
Trenton, NJ 08650

- All applications are processed at the state office in Trenton unless your client meets one of the following qualifications a) a woman who received Presumptive Eligibility (PE) at a certified PE provider, b) a legal permanent resident, or c) a non-qualified pregnant woman. In any of these cases, his/her application will be processed at the Atlantic County office, not the state office. To check on these applications your client can call **609-348-3001**. (**Note: The letter your client received in the mail confirming the application should identify which office is processing his/her application**)
 - If documents need to be sent by mail to the Atlantic County office, send to:

Department of Family and Community Development
1333 Atlantic Avenue
Atlantic City, NJ 08401

- Remember it is **especially important for clients who received Presumptive Eligibility (PE) to follow up so that they receive full insurance coverage**.
- If a woman has **recently had a baby** and needs to add the baby to her insurance, tell her to call the Atlantic County Department of Family and Community Development at **609-348-3001** as soon as possible. **It is a great idea to advise the client to bring documents to the hospital with her.**
- **Inform your client that they must renew their insurance every year.** NJ FamilyCare will check to see if anything has changed in the family situation. They may be sent a form to confirm their household size, or other information to complete. It is very important they respond to the requests for documentation so the insurance is not lost or interrupted.
- Give your client the NJ FamilyCare flyer. The flyer has the phone number and website on it for easy reference.

2. Center For Family Services (Appendix F)

- The Center For Family Services has healthcare navigators that can help answer any questions your client may have about the NJ FamilyCare process. They can call **1-877-922-2377** or visit **centerffs.org**.
- The Center For Family Services' health care navigators can also help clients enroll in health insurance through the Marketplace if they are not eligible for NJ FamilyCare.
- Clients can visit **centerffs.org** to find local events in which a health care navigator will be available to share information about NJ FamilyCare and health insurance through the Marketplace.
- Give your client the Center For Family Services Flyer. The flyer provides information about their program and includes their phone number and website address.

5 Provide Resources

While your clients wait for their applications to be processed, or if they are not eligible for NJ FamilyCare, they will need to know where they can go to get healthcare services. Refer them to the organizations below. To request more copies of resources, reach out to Atlantic County Health Educator at 609-645-7700 x4227.

1. Federally Qualified Health Centers (FQHCs)

Atlantic County Federally Qualified Health Centers

Atlantic County Health Centers offer a wide range of health care services for your entire family. You do not need health insurance to get care at a health center. Centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare, and private insurance. For more information, your local health center is your ally to go to.

Services available vary by location and include:

<ul style="list-style-type: none"> Family Services Behavioral Health Services Oral Care Immunizations Diabetes Care Wound Care Substance Use Treatment Case Management 	<ul style="list-style-type: none"> Nutrition Counseling Health Coaching Smoking Cessation Sexual Health Services Wound Care Substance Use Treatment Case Management
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Atlantic City	Atlantic City Health Centers - Northfield 1550 Atlantic Avenue Atlantic City, NJ 08402 Phone: 609-427-4222
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Atlantic County Division of Public Health
301 South Stone Road
Northfield, NJ 08222
Phone: 609-648-2722
www.atlanticcountynj.org

Atlantic County Executive: Dennis L. Johnson Atlantic County Board of Public Health: Amy S. Clardy, Chairwoman

- Federally Qualified Health Centers FQHCs provide their services to **all persons regardless of ability to pay**. They use an approved sliding-fee scale that is based on patients' family income and size. FQHCs serve the **uninsured and underinsured**, as well as patients with Medicaid, Medicare, and private insurance.

Services provided at the centers include:

- Pediatric Services
- Women's Health/Prenatal Care
- Internal and Family Medicine
- Mental Health
- Dental Care
- Evaluation for Sexually Transmitted Diseases
- Laboratory Services
- Referrals for Specialty Care

FQHCs in Atlantic County include:

- AtlantiCare**
- Southern Jersey Family Medical Centers (SJFMC)**
- Give the **Federally Qualified Health Center** flyer to your client. This handout lists the contact information for each location.

2. Prenatal Care

Atlantic County Prenatal Care

Prenatal care is the health care you receive while you are pregnant. It is important to get prenatal care early in your pregnancy. Prenatal care can help you and your baby stay healthy. Prenatal care can include screening tests, ultrasounds, and other services. Prenatal care can also help you prepare for your pregnancy with a high school diploma or GED. Prenatal care can also help you prepare for your pregnancy with a high school diploma or GED. Prenatal care can also help you prepare for your pregnancy with a high school diploma or GED. Prenatal care can also help you prepare for your pregnancy with a high school diploma or GED.

Health locations accept women with or without insurance.

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- Pregnant women should be referred to Reliance Medical Group or Southern NJ Family Medical Centers for prenatal care. **Both centers accept women with or without insurance.**
- Women who are eligible can apply for NJ FamilyCare at either of these centers and can also receive immediate, temporary Medicaid coverage (Presumptive eligibility).
- It is recommended that women receive prenatal care in the first three months of their pregnancy to increase their chances of having a healthy baby.
- Give the **Prenatal Care** flyer to your client if they need prenatal services. This handout lists the contact information for the aforementioned facilities.
- Refer to Southern New Jersey Perinatal Cooperative Healthy Families Home Visiting Program at 609-345-6420.

3. Dental Care

Atlantic County Dental Services

1 Rutgers School of Dental Medicine

The Rutgers School of Dental Medicine provides a full range of oral health services for low-income families and senior citizens at the John H. Cronin Dental Center in Northfield and University Dental Center in Galloway. Diagnostic, preventative, restorative, periodontics, prosthodontics, endodontic, surgical and emergency care procedures are available to patients. Medicaid is accepted and a sliding fee schedule is available for those without insurance. Some private insurances are also accepted. Call one of the locations below to schedule an appointment or for more information.

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2 Southern Jersey Family Medical Centers (SJFMC)

SJFMC provides primary dental services including treatment of tooth decay, gum disease, and oral cancer examinations. You do not need health insurance to get care at SJFMC. These centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare, and private insurance. If you are uninsured, your bill will be based on your ability to pay.

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- The Rutgers School of Dental Medicine provides a full range of oral health services for low-income families and senior citizens at the John H. Cronin Dental Center in Northfield and University Dental Center in Galloway. Diagnostic, preventative, restorative, periodontics, prosthodontics, endodontic, surgical and emergency care procedures are available to patients. Medicaid is accepted and a sliding fee schedule is available for those without insurance. Some private insurances are also accepted.
- SJFMCs provide primary dental services including treatment of tooth decay, gum disease, and oral cancer examinations. You do not need health insurance to get care at SJFMC. These centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare, and private insurance. If you are uninsured, your bill will be based on your ability to pay.
- Give the **Dental Services** flyer to your client if they are in need of dental care. This handout lists the contact information for each of the facilities mentioned.

4. Prescription Assistance Card



- Any county residents without prescription coverage can use this card to save money on prescription drugs. Those who do receive insurance coverage may also still be able to benefit from the discount card, since it may save them money on prescription drugs if their plan does not adequately cover the cost. (Note: This is not insurance, it is a prescription savings program approved by the county).
- Residents can save an average of 24% of the retail price of prescription medications.
- The card can be used at 68,000 pharmacies nationwide.
- Provide the **Prescription Discount Card** flyer to your client. The flyer has a phone number which can be called to find out more information. It also has a website address where residents can visit to print out a prescription assistance card, and find out about participating pharmacies.

5. MyCountyCares Dental Plan



- MyCountyCare Dental Plan is meant for those who do not have insurance and need help paying for their dental bills (it is not an insurance plan).
- MyCountyCares Dental Plan can save participating members on savings of up to 60% on most dental procedures including routine oral exams, dentures, root canals, crowns and more.

Sample Dental Savings*

Procedure Description	Regular Cost	Plan Cost	\$ Savings	% Savings
Adult Cleaning	\$118	\$56	\$63	53%
Child Cleaning	\$83	\$41	\$41	50%
Routine Checkup	\$69	\$28	\$41	59%
Four Bitewing X-rays	\$80	\$37	\$43	53%
Composite (White) Filling Code	\$188	\$92	\$96	51%
Crown (porcelain fused to noble metal)	\$1332	\$721	\$611	46%
Complete Upper Denture	\$1911	\$935	\$976	51%
Molar Root Canal	\$1299	\$676	\$623	48%
Extraction (single tooth)	\$221	\$94	\$128	58%

*Prices are subject to change

- This program would be appropriate for those who do not qualify for NJ FamilyCare and need extra help paying their dental bills. Give the **MyCountyCares Dental Plan** flyer to those you feel may benefit from this program.

APPENDICES



Affordable health coverage. Quality care.

Appendix A

Income Chart effective January 1, 2019

1-800-701-0710

TTY: 1-800-701-0720

www.njfamilycare.org

FAMILY SIZE *	Adult(s) (Age 19-64)	Pregnant Women (Any Age)	Children (Under Age 19)					
	Federal Poverty Level % (FPL)							
	0 - 138%	0 - 205%	0 - 147%	> 147 - 150%	> 150 - 200%	> 200 - 250%	> 250 - 300%	> 300 - 355%
	Maximum Monthly Income							
1	\$1,437	N/A	\$1,531	\$1,562	\$2,082	\$2,603	\$3,123	\$3,695
2	\$1,945	\$2,889	\$2,072	\$2,114	\$2,819	\$3,523	\$4,228	\$5,003
3	\$2,453	\$3,644	\$2,613	\$2,667	\$3,555	\$4,444	\$5,333	\$6,311
4	\$2,962	\$4,399	\$3,155	\$3,219	\$4,292	\$5,365	\$6,438	\$7,618
5	\$3,470	\$5,155	\$3,696	\$3,772	\$5,029	\$6,286	\$7,543	\$8,926
6	\$3,978	\$5,910	\$4,238	\$4,324	\$5,765	\$7,207	\$8,648	\$10,233
Each Additional	\$509	\$756	\$542	\$553	\$737	\$921	\$1,105	\$1,308
Monthly Premium	No premium	No premium	No premium	No premium	No premium	\$44.50 per family	\$90.00 per family	\$151.50 per family
Copayments	No copay	No copay	No copay	No copay	\$5 - \$10	\$5 - \$35	\$5 - \$35	\$5 - \$35

* The size of your family may be determined by the **total number** of parent(s) or caretaker(s), and all blood-related children under the age of 21 **who are tax dependent, as well as any other tax dependent** residing in the home.



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.
- 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.



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.



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 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
- **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? <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.

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

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?
 Yes 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?
 Yes No

15. 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:

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

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) <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 \$ _____	
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) <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 \$ _____	
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.

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 _____

- 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 _____ Policy # _____

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/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)
-----------	-------------------

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**

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)



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.

	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? _____



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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)



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Appendix C

Uninsured Pregnant Women: Citizen or Qualifying Immigrant

Presumptive Eligibility for 45 Days  Temporary Eligibility 


Need to return required documents to address on confirmation letter to become real/permanent Medicaid



Client/patient will get the Medicaid Card in the Mail (white with blue outline of the State of NJ). **THIS IS a Temporary Card until all documents are returned and card will be reprogrammed as permanent card!!! It will stop working if all documents are not returned by the 45 days! NOTE: This temporary card may only be used at the site where PE was done.**

You will receive notification on where to send needed information

Where do you send/take documents?

Mail  To address on **Confirmation Letter**

Fax  To fax Number on **Confirmation Letter**

Or Take To:

1. 1333 Atlantic Ave., Atlantic City, NJ 08401
2. SJFMC in Hammonton from 8:30 AM to 3:00 PM Mondays and Tuesdays

Who is the case being processed by?

If the address on Confirmation Letter is:

- **Atlantic County Department of Family and Community Development:**
It is **Atlantic County Medicaid**
- Somewhere in **Trenton NJ:**
It is **NJ State Department of Human Services**
- ✓ **All documents should be returned within 45 days**
- ✓ **Extension may be made before 45 days by the PE Coordinator**
- ✓ **SSN needed**
- ✓ **No PO Boxes, must be a street address**
- ✓ **When your Medicaid is finalized, the blue and white card is electronically updated.**
- ✓ **Put your Medicaid number on the back of the blue and white card with a permanent marker**

Change of address? Call 609-348-3301 and ask for NJ Family Care

NJ Department of Human Services NJ FamilyCare Online Application

Monday, April 18, 2016

User: [REDACTED]

Close

List Applications	Enter Application	Users
Select a Language: ENGLISH ▾		
Start	Address	Household
Member Info	Income	Health Plan
Review	Sign	Submit
Confirmation		

Confirmation

YOUR APPLICATION HAS BEEN SUCCESSFULLY SUBMITTED

Thank you [REDACTED] for submitting your application for NJ FamilyCare electronically to the Atlantic County Department of Family and Community Development, 1333 Atlantic Avenue, Atlantic City, NJ 08401. You may make additions or corrections by contacting the Atlantic County Department of Family and Community Development at (609) 348-3001 and referring to the confirmation number printed below. Please allow at least a week before calling.

Your application has also been submitted electronically to the Presumptive Eligibility Unit.

Please **DO NOT** submit another online application and **DO NOT** mail in a hard copy.

It may take up to 45 days before you hear about your application.

Note: You may print a copy of the application for your records by clicking on the button below.

Submission of this application does not mean you have immediate coverage.

Your application was submitted on 4/18/2016.
Your Confirmation Number is 01160400334

Print the Application

Print this page

Done

Best printed on legal-size paper.

Print Health Coverage from Jobs Form

Print and complete this form if someone in the household is eligible for health coverage from a job.

Print Appendix B

Print and complete this form if you or a family member are Native American or Alaska Native.



Dennis Levinson
County Executive

Atlantic County

Department of Family & Community Development

Temp Rev: 6/15

Appendix E

New Jersey Family Care On-Line App

J. Forrest Gilmore
Department Head
609/343-2377 Fax: 343-2374

MN:

Date:

Confirmation #:

Previous Case #:

Dear: Customer

We have received your application for NJ Family Care, but we are **unable** to process your application until we receive **copies** of the following documentation:

Proof of Income Documentation:

One pay stub showing gross income for each job for every working person in the household from the current month of employment or a copy of the most recent 1040 Tax return (first and signature page only).

And/or

Proof of all other household income: such as Social Security Award Letter, Unemployment, State Disability Benefits, Interest and/or Dividends, Rental income, Alimony, etc.

Proof of US Citizenship/Naturalized Citizen Documentation:

- State Birth Certificate
- U.S. Passport
- Naturalization Papers

Proof of Alien Status Documentation:

- Resident Alien Cards. (Must copy both front and back sides) *Must be resident for 5yrs.*
- I-94 or I-797A document must be stamp with Codes I-551, 207, 208, 212 or 203.
- Employment Authorization Card (I-688B) or "Work Permit" only those with an A3, A5, or A10 are eligible for NJFC.

Proof of Non-Citizens Documentation:

- Passport
- Birth Certificate

Identification Documentation:

- Driver License
- Photo ID

Other Documentation:

- Social Security Card (For everyone in the household)
- Marriage or Divorce Papers
- Single Fathers: Custody Papers from the courts and school records

If applicant **has** current health insurance, a copy of the front and back of the insurance card and if applicant **had** health insurance in the past 3 months, a letter showing that health insurance was terminated.

Please attach **ALL** paperwork together with your *Confirmation #* on each page and a copy of this letter. Please mail the requested information immediately to your Medicaid case worker at: 1333 Atlantic Avenue Atlantic City, NJ 08401 **Attention: 7th floor Medicaid** or FAX (609) 343-2370 **Attention (Eligibility Worker)**. When your information is received, we will process your application, if we do not hear from you by _____ we will assume you are no longer interested in receiving health insurance coverage.

Please contact your case worker if you have any questions or need assistance.

Eligibility Worker' Name:

(609) 348-3001 Ext.



Affordable health coverage. Quality care.

Philip D. Murphy,
Governor
Sheila Y. Oliver,
Lt. Governor
State of New Jersey

CHILDREN and ADULTS UNDER AGE 65

NJ FamilyCare is publicly funded health coverage for NJ residents. It provides free or low cost quality health care. The NJ FamilyCare program includes CHIP, Medicaid and Medicaid expansion populations.

What's Covered?

NJ FamilyCare offers full health care coverage through health plans contracted by the state.

NJ FamilyCare covers most health care needs including:

- doctor visits
- x-rays
- eyeglasses
- prescriptions
- hospitalization
- mental health services
- lab tests
- dental
- specialist visits

Who is Eligible:

Qualified NJ residents of any age can be eligible for NJ FamilyCare. This includes children, parents, caretaker relatives, and adults without dependent children. Eligibility is based on the income and household size that was reported on applicant's latest federal tax return. However, NJ FamilyCare can use other sources, such as pay stubs, to verify information. Income eligibility for children is higher than income eligibility for adults. (See chart)

MAXIMUM MONTHLY INCOME as of January 1, 2019			
Family Size and Monthly Income Reported on your Federal Taxes			
Family Size*	Children (Under Age 19)	Parent(s) & Single Adult(s) (Age 19-64)	Pregnant Women (Any Age)
1	\$ 3,695	\$ 1,437	N/A
2	\$ 5,003	\$ 1,945	\$ 2,889
3	\$ 6,311	\$ 2,453	\$ 3,644
4	\$ 7,618	\$ 2,962	\$ 4,399
5	\$ 8,926	\$ 3,470	\$ 5,155
6	\$10,233	\$ 3,978	\$ 5,910
Each Add'l Member	\$ 1,308	\$ 509	\$ 756

* The size of your family may be determined by the total number of parent(s) or caretaker(s), and all blood-related children under the age of 21 who are tax dependent, as well as any other tax dependent residing in your home.

What Does it Cost?

For many people, NJ FamilyCare will cost nothing: no monthly premiums or co-payments.

For higher income families with children there is a sliding scale for co-payment's and monthly premiums.

Are There Any Restrictions?

Pre-existing conditions do not affect eligibility. In most cases, children must be without medical insurance for at least 3 months to qualify. Because there are exceptions, it is a good idea to call NJ FamilyCare in case you have a question.

Adults must have Legal Permanent Resident status for at least five years to be eligible. Children and pregnant women, regardless of their date of entry into the U.S., can be eligible if they are legal residents. For undocumented residents, their children may be eligible if born in the U.S.

How to Find Out More? To find out if you are eligible, or for more information, call or visit our website.

1-800-701-0710

(Multilingual operators available)

www.njfamilycare.org

Apply online!

TTY 1-800-701-0720

(For hearing impaired individuals)

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).

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).

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、年龄或残障而进行歧视。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)。



Navigator Exchange Program



The Affordable Care Act may help you gain access to quality, affordable healthcare.

Financial help is available to lower monthly costs.



Free, in-person enrollment help is available in your community.



Coverage helps protect both your health and wallet.



New plans and prices are available.



There may be a financial penalty for not having coverage.



Need help understanding your options?

For free, in-person healthcare enrollment assistance call:

1.877.9.NAVIG8

(1.877.962.8448)

centerffs.org/navigator

Health Insurance **Marketplace**

healthcare.gov or cuidadodesalud.gov

RESOURCES

Atlantic County Federally Qualified Health Centers

Federally Qualified Health Centers offer a wide range of health care services for your entire family. You do not need health insurance to get care at a center. Centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare, and private insurance. If you are uninsured, your bill will be based on your ability to pay.



Services available vary by location and include:

- Pediatric Services
- Women's Health/Prenatal Care
- Internal and Family Medicine
- Geriatrics
- Mental Health
- Dental Care
- Social Services
- Case Management
- Nutritional Counseling
- Health Education
- HIV/AIDS Testing
- Laboratory Services
- Screening for Sexually Transmitted Infections or Diseases
- Referrals for Specialty Care
- Patient Transportation

AtlantiCare	AtlantiCare Health Services - Adult Medicine 1401 Atlantic Avenue Suite 2600-2800 Atlantic City, NJ 08401	Phone: 609-572-6055
	AtlantiCare Health Services - Adult Medicine 54 W. Jimmie Leeds Road Galloway, NJ 08205	Phone: 609-404-7300
	AtlantiCare Health Services - Pediatrics 1401 Atlantic Avenue Suite 2200 Atlantic City, NJ 08401	Phone: 609-572-8686

Southern Jersey Family Medical Centers (SJFMC)	Atlantic City Center 1301 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-572-0000
	Atlantic City Women & Children's Pavilion 1125 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-348-0066
	English Creek Center 3003 English Creek Avenue Egg Harbor Twp., NJ 08234	Phone: 609-481-3185
	Hammonton Center 860 S. White Horse Pike, Building A Hammonton, NJ 08037	Phone: 609-567-0200
	Pleasantville Center 932 S. Main Street Pleasantville, NJ 08232	Phone: 609-383-0880

Atlantic County Division of Public Health
201 South Shore Road
Northfield, NJ 08225
Phone: 609-645-5933
www.atlantic-county.org



Atlantic County Executive
Dennis Levinson

Atlantic County Board of Freeholders
Amy L. Gatto, Chairwoman

Atlantic County Prenatal Care

Prenatal care is the health care you receive while you are pregnant. It is recommended that you begin prenatal care within the first three months of your pregnancy. Starting prenatal care early can improve your chances of having a healthy baby. Prenatal care can include screening tests, education on healthy lifestyle, and treatment of conditions that may affect your pregnancy such as high blood pressure or diabetes. Pregnancy testing and prenatal care are offered at the locations listed below.



*Both locations accept women with or without insurance.

Reliance Medical Group	Reliance OB/GYN Atlantic City 4401 Ventnor Avenue Atlantic City, NJ 08401	Phone: 609-344-1836
	Reliance OB/GYN Somers Point 155 Medical Center Way Somers Point, NJ 08244	Phone: 609-653-1016
Southern Jersey Family Medical Centers (SJFMC)	Atlantic City Center 1301 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-572-0000
	Atlantic City Women & Children's Pavilion 1125 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-348-0066
	English Creek Center 3003 English Creek Avenue Egg Harbor Twp., NJ 08234	Phone: 609-481-3185
	Hammonton Center 860 S. White Horse Pike Bldg. A Hammonton, NJ 08037	Phone: 609-567-0200
	Pleasantville Center 932 S. Main Street Pleasantville, NJ 08232	Phone: 609-383-0880

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Dennis Levinson

Atlantic County Board of Freeholders
Amy L. Gatto, Chairwoman

Atlantic County Dental Services

1 Rutgers School of Dental Medicine

The Rutgers School of Dental Medicine provides a full range of oral health services for low-income families and senior citizens at the John H. Cronin Dental Center in Northfield and University Dental Center in Galloway. Diagnostic, preventative, restorative, periodontics, prosthodontics, endodontic, surgical and emergency care procedures are available to patients. Medicaid is accepted and a sliding fee schedule is available for those without insurance. Some private insurances are also accepted. Call one of the numbers below to schedule an appointment or for more information.



Cronin Dental Center	235 Dolphin Avenue Northfield, NJ 08225	Phone: 609-645-5814
University Dental Center	4 E. Jimmie Leeds Road Suite 6 Galloway, NJ 08205	Phone: 609-652-0501

2 Southern Jersey Family Medical Centers (SJFMC)

SJFMC provides primary dental services including treatment of tooth decay, gum disease, and oral cancer examinations. You do not need health insurance to get care at SJFMC. These centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare, and private insurance. If you are uninsured, your bill will be based on your ability to pay. Contact SJFMC at any of the following locations to schedule an appointment or for more information.

Atlantic City Center	1301 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-572-0000
English Creek Center	3003 English Creek Avenue Egg Harbor Twp., NJ 08234	Phone: 609-481-3185
Hammonton Center	860 S. White Horse Pike Hammonton, NJ 08037	Phone: 609-567-0200
Pleasantville Center	932 S. Main Street Pleasantville, NJ 08232	Phone: 609-383-0880

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Dennis Levinson

Atlantic County Board of Freeholders
Amy L. Gatto, Chairwoman

Atlantic County Prescription Discount Card

Americans are paying more for prescription drugs than ever before. Without prescription coverage, staying healthy can come at a high price. The Atlantic County Prescription Discount Card provided to you in a joint effort with the National Association of Counties (NACo), can save you money on many of your prescription purchases.

Any county resident with or without prescription coverage can use this program. If you have insurance for prescription drugs, you may still benefit from the discount card, since it may save you money on prescription drugs your existing plan does not cover.

Everyone is eligible!

- No income requirements
- No age requirements
- Unlimited use for the whole family

The Atlantic County Prescription Discount Card is:

- **Valuable.** Save an average of 24% off the pharmacy's regular price on all commonly prescribed prescriptions and an average savings of 50% on 90-day supplies of select generics through mail service. Savings are also available on high-tech and injectable drugs through the Caremark specialty pharmacy.
- **Easy.** There are no claim forms to fill out and no annual fee to pay.
- **Convenient.** There are more than 68,000 participating pharmacies nationwide, over 50 are located right here in the county!



Contact Information

Phone	Call 1-877-321-2652 for more information.
Website	Visit http://www.nacorx.org/ to print out a card and find participating pharmacies.

Atlantic County Division of Public Health
201 South Shore Road
Northfield, NJ 08225
Phone: 609-645-5933
www.atlantic-county.org



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Dennis Levinson

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Amy L. Gatto, Chairwoman



**ATLANTIC COUNTY,
NEW JERSEY**



MYCOUNTYCARES DENTAL PLAN

Programs starting at **\$6.95 per month and \$69 per year for individuals, or \$8.95 per month and \$79 per year for families!***

Save **5% to 60%** on dental procedures including routine oral exams, cleanings, dentures, crowns and more!

*Plus a one-time, non-refundable \$10 processing fee.

**Call (877) 354-6226 or visit
www.mycountydental.com/atlantic**

START SAVING TODAY!



Save on your dental needs

- ▶ Save 5% to 60% on most dental procedures including routine oral exams, unlimited cleanings and major work such as dentures, root canals and crowns through one of the largest dental networks nationally with a focus on neighborhood dentists.



ATLANTIC COUNTY,
NEW JERSEY



MYCOUNTYCARES DENTAL PLAN

Member Name: _____
(Please print your name.)

*Member ID: _____

*Dental Network: _____

*Call (877) 354-6226 to get your member ID and dental network.)

Dental Plan Rates*

Individual: \$6.95/mo or \$69.00/yr

Family: \$8.95/mo or \$79.00/yr

*Plus a one-time, non-refundable \$10 processing fee.

Sample Dental Savings*

Procedure Description	Regular Cost *	Plan Cost**	\$ Savings	% Savings
Adult Cleaning	\$118	\$56	\$63	53%
Child Cleaning	\$83	\$41	\$41	50%
Routine Checkup	\$69	\$28	\$41	59%
Four Bitewing X-rays	\$80	\$37	\$43	53%
Composite (White) Filling Code	\$188	\$92	\$96	51%
Crown (porcelain fused to noble metal)	\$1332	\$721	\$611	46%
Complete Upper Denture	\$1911	\$935	\$976	51%
Molar Root Canal	\$1299	\$676	\$623	48%
Extraction (single tooth)	\$221	\$94	\$128	58%

* Regular cost is based on the national average of the 80th percentile usual and customary rates as detailed in the 2014 FairHealth Report in the Los Angeles, Orlando, Chicago and New York City metropolitan statistical areas.

** These fees represent the average of the assigned Maximum Care (DN15) fees in the Los Angeles, Orlando, Chicago and New York City metropolitan statistical areas.

Prices subject to change.

To learn more about the MyCountyCares Dental Plan, call **(877) 354-6226** or visit **www.mycountydental.com/atlantic**

Disclosures:

THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This plan does not meet the minimum creditable coverage requirements under M.G.L. c.111M and 956 CMR 5.00. This plan is not a Qualified Health Plan under the Affordable Care Act. This is not a Medicare prescription drug plan. The range of discounts will vary depending on the type of provider and service. The plan does not pay providers directly. Plan members must pay for all services but will receive a discount from participating providers. The list of participating providers is at www.mycountydental.com/atlantic. A written list of participating providers is available upon request. You may cancel within the first 30 days after receipt of membership materials and receive a full refund, less a nominal processing fee (nominal fee for MD residents is \$5, AR and TN residents will be refunded processing fee). Discount Medical Plan Organization and administrator: Careington International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-441-0380. This plan is not available in Vermont or Washington.

Atlantic County Breastfeeding Support

1

Gateway WIC

WIC is a special supplemental food and nutrition education program for **W**omen, **I**nfants, and **C**hildren. To be eligible, you must be either:

- A pregnant woman
 - A postpartum woman (up to six months after delivery)
 - A breastfeeding woman up to 1 year
 - An infant or child under 5 years of age
- And:
- Have low or moderate income
 - Be at nutritional risk



WIC provides supplemental nutritious foods, nutrition education, and breastfeeding services (breastfeeding support groups, one-on-one counseling, and a 24-hour phone line to answer breastfeeding questions). Call the WIC office nearest you for more information.

Locations

Atlantic City	139 N. Iowa Ave Atlantic City, NJ 08401	Phone: 609-246-7767
Egg Harbor City	300 Philadelphia Ave Suite B Egg Harbor City, NJ 08215	Phone: 609-593-3940
Galloway	333 E. Jimmie Leeds Road Galloway, NJ 08205	Phone: 609-382-5050

Southern NJ Perinatal Cooperative

Southern New Jersey Perinatal Cooperative offers breastfeeding support, free educational materials, and has a Board Certified Lactation Consultant (IBCLC) available to answer any questions. Call the number below for breastfeeding help.

Location

Pleasantville	605 W. California Ave. Pleasantville, NJ 08232	Phone: 609-345-6420 Website: www.snjpc.org
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3 **AtlantiCare**

AtlantiCare offers breastfeeding classes and lactation consultations. Topics covered in the breastfeeding classes include: latching-on, proper positioning, and establishing a milk supply. There is a small fee for the breastfeeding classes. Call the number below or visit the website to register for a class; or call the lactation consultant for breastfeeding information.

Location

Pomona	Hackberry Building 100 Hackberry Way Pomona, NJ 08240	Phone: 1-888-569-1000 Website: www.atlanticare.org/index.php/events-classes Lactation Consultant: 609-404-3837
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4 **Shore Medical Center**

Shore Medical Center provides breastfeeding classes, breastfeeding support groups, and private lactation consultations. Lactation consultations are available both in-person and over the phone. Call the number below if you need breastfeeding education, support, or just need breastfeeding questions answered.

Location

Somers Point	100 Medical Center Way Somers Point, NJ 08244	Shore Beginnings Phone: 609-653-3238 Website: http://shoremmedicalcenter.org
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5 **La Leche League**

The mission of La Leche League USA is to help mothers to breastfeed through mother-to-mother support, encouragement, information, and education. They hold monthly meetings led by an accredited La Leche League Leader. Expectant mothers, new mothers, babies, and experienced nurses are all welcome. You can also contact a La Leche League leader below to have your breastfeeding questions answered.

Location

Linwood Chapter	Linwood Library 301 Davis Ave Linwood, NJ 08221	Phone: 609-204-5067 or 609-994-4177 Meets the 3 rd Wednesday of each month from 7:00PM-9:00PM
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Atlantic County Division of Public Health
201 South Shore Road
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www.atlantic-county.org



Atlantic County Executive
Dennis Levinson

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Amy L. Gatto, Chairwoman

Atlantic County Child Immunizations

Vaccines are important to protect infants, children, and adolescents from potentially harmful diseases. Daycares and schools require vaccinations to protect the community and lower rates of vaccine-preventable diseases.

If your child does not have health insurance and needs vaccinations, the organizations listed below can help. Call to schedule an appointment.



Atlantic County Division of Public Health	Public Health Clinic Stillwater Building 201 S. Shore Road Northfield, NJ 08225	Phone: 609-645-7700 ext. 4500	Immunizations are available for children who are uninsured or who have NJ FamilyCare A Insurance and reside in Atlantic County (call to check eligibility).
	Public Health Clinic 310 Bellevue Avenue Hammonton, NJ 08037	Phone: 609-645-7700 ext. 4500	
AtlantiCare Health Services - Pediatrics	1401 Atlantic Avenue Suite 2200 Atlantic City, NJ 08401	Phone: 609-572-8686	Immunizations are available for children who are uninsured or who have NJ FamilyCare A Insurance.
Southern Jersey Family Medical Centers (SJFMC)	Atlantic City Center 1301 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-572-0000	Immunizations are available to residents with or without insurance. If you are uninsured, your bill will be based on your ability to pay.
	Atlantic City Women & Children's Pavilion 1125 Atlantic Avenue Atlantic City, NJ 08401	Phone: 609-348-0066	
	English Creek Center 3003 English Creek Ave. Egg Harbor Twp., NJ 08234	Phone: 609-481-3185	
	Hammonton Center 860 S. White Horse Pike, Bldg. A Hammonton, NJ 08037	Phone: 609-567-0200	
	Pleasantville Center 932 S. Main Street Pleasantville, NJ 08232	Phone: 609-383-0880	

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**INSURANCE QUICK REFERENCE GUIDE FOR
ENROLLING CLIENTS IN NJ FAMILY CARE**

A collaborative project between the Healthy Mothers, Healthy Babies Coalition of the Southern New Jersey Perinatal Cooperative and the Atlantic County Division of Public Health.

Printed courtesy of the Southern NJ Perinatal Cooperative. 3/28/2019

For additional copies contact SNJPC Shore Office: 609.345.6420 snjpc.org