



State of New Jersey

DEPARTMENT OF EDUCATION
PO Box 500
TRENTON, NJ 08625-0500

JON S. CORZINE
Governor

LUCILLE E. DAVY
Commissioner

September 2008

Dear Parent (s)/Guardian(s):

Governor Corzine has made a commitment for New Jersey to provide universal health insurance to children and affordable options for parents/guardians with the recent signing of new legislation. This new law mandates that all children age 18 and under have health insurance.

The requirement for health insurance coverage can be met in a variety of ways: (1) through a health insurance plan provided by your employer; (2) through a health insurance policy you purchase directly; and (3) through NJ FamilyCare which provides free or low cost insurance for children and their parents/guardians. Enrollment in school insurance *only* does not satisfy this new mandate. For more information about NJ Family Care or to apply, please call 1-800-701-0710 or visit www.njfamilycare.org.

Parents or guardians who earn too much to qualify for NJ FamilyCare can purchase health insurance for their children at reasonable rates through another program called the NJ FamilyCare Advantage program, which is administered by Horizon NJ Health. For more information about this program, please call NJ FamilyCare Advantage at 1-800-637-2997.

As the law also requires, the New Jersey Department of Education is now assisting the New Jersey Department of Human Services in its efforts to identify uninsured children and to help families access free or low cost health insurance or visit www.horizonNJhealth.com.

Healthy children make better students! Our goal is to assist all New Jersey families in securing no cost or affordable insurance which will provide access to quality healthcare. If you have any questions about this new requirement, please call 1-800-701-0710.

Sincerely,

Lucille E. Davy
Commissioner
Department of Education



NJ FAMILY CARE

Affordable health coverage. Quality care.

Offered by the State of New Jersey

Jon S. Corzine, Governor
State of New Jersey

NJ FamilyCare provides quality free or low-cost health coverage for uninsured children 18 and younger and low-income parents. This program already covers more than a half million New Jersey children.


What's Covered?

NJ FamilyCare offers full health care coverage through established Health Maintenance Organizations (HMOs) that operate throughout the state.

NJ FamilyCare covers just about every health care need, including:

doctor visits	x-rays	eyeglasses
prescriptions	hospitalization	mental health services
lab tests	dental (for most kids)	specialist visits

Who is Eligible?



Only children 18 and younger and certain low-income parents living in New Jersey are eligible for NJ FamilyCare. Eligibility is based on a family's size, including children and parents, and monthly income. Assets are not considered. (See the chart at right.)

What Does it Cost?

For many families, it costs nothing: no monthly premiums or co-payments. For families with higher monthly incomes, there is a sliding scale for small co-payments and monthly premiums may be required.

Are There Any Restrictions?

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

Most immigrants whose documents allow them to live here permanently are eligible. 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 on line!

TTY 1-800-701-0720

(For hearing impaired individuals)

2008 Maximum Family Income

Please review the chart. It is based on family size and monthly income before taxes. If you earn less than the amount listed and your family is uninsured, you and/or your children are probably eligible.

2008 Maximum Gross Monthly Income Limits

Family Size*	Children's Coverage (Age 18 and younger)	Parent/Guardian Coverage
2	\$4,084	\$2,334
3	\$5,134	\$2,934
4	\$6,184	\$3,534
5	\$7,234	\$4,134
6**	\$8,284	\$4,734

* Includes parents/guardians and their children in the household

**For larger families, call to determine your monthly guidelines





Affordable health coverage. Quality care.

What it costs



Affordable health coverage. Quality care.

1-800-701-0710

1-800-701-0720(TTY)

www.njfamilycare.org

Year 2008 Gross Income Guidelines*

Federal Poverty Level Range	Family Size One Child	Family Size 2 people	Family Size 3 people	Family Size 4 people	Family Size 5 people	Family Size 6 people	Family Size 7 people	Premiums	Copayments
	Maximum Annual/ Monthly Income	Maximum Annual/ Monthly Income	Maximum Annual/ Monthly Income	Maximum Annual/ Monthly Income	Maximum Annual/ Monthly Income	Maximum Annual/ Monthly Income	Maximum Annual/ Monthly Income		
0 - 133%	\$13,832	\$18,620	\$23,408	\$28,196	\$32,984	\$37,772	\$42,560	No premium	No copay
	\$1,153	\$1,552	\$1,951	\$2,350	\$2,749	\$3,148	\$3,547		
> 133 - 150%	\$15,600	\$21,000	\$26,400	\$31,800	\$37,200	\$42,600	\$48,000	No premium	No copay
	\$1,300	\$1,750	\$2,200	\$2,650	\$3,100	\$3,550	\$4,000		
> 150 - 200%	\$20,800	\$28,000	\$35,200	\$42,400	\$49,600	\$56,800	\$64,000	\$19.00 monthly per family**	\$5 - \$10
	\$1,734	\$2,334	\$2,934	\$3,534	\$4,134	\$4,734	\$5,334		
> 200 - 250%	\$26,000	\$35,000	\$44,000	\$53,000	\$62,000	\$71,000	\$80,000	\$38.50 monthly per family	\$5 - \$35
	\$2,167	\$2,917	\$3,667	\$4,417	\$5,167	\$5,917	\$6,667		
> 250 - 300%	\$31,200	\$42,000	\$52,800	\$63,600	\$74,400	\$85,200	\$96,000	\$76.00 monthly per family	\$5 - \$35
	\$2,600	\$3,500	\$4,400	\$5,300	\$6,200	\$7,100	\$8,000		
> 300 - 350%	\$36,400	\$49,000	\$61,600	\$74,200	\$86,800	\$99,400	\$112,000	\$128.00 monthly per family	\$5 - \$35
	\$3,034	\$4,084	\$5,134	\$6,184	\$7,234	\$8,284	\$9,334		

* Family size larger than 7 people call 1-800-701-0710 for guidelines.

**Parents at this income level pay an additional monthly premium of \$32.00 for first parent and \$13.50 for the second parent.

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1. Household Information

Home Address: _____ Apt. #/Floor: _____ Home Phone: _____ Cell Phone: _____ Other Phone: _____
 City: _____ County: _____ State: _____ Zip: _____ Language spoken at home: _____

Mailing Address, if different: _____ City: _____ State: _____ Zip: _____

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

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

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

Children First Name	Last Name	Do you want NJ FamilyCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex M/F	Social Security Number (Required for those applying)	Race/Ethnicity (only for those applying) **See codes below	Birth Date MM/DD/YYYY	US Citizen? (See instructions)	Full-time Student?	Other health insurance now? (see instructions)	Other health insurance within the past 3 months? (see instructions)	How is this child related to the 1st parent/guardian listed above?	How is this child related to the 2nd parent/guardian listed above?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		- -		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other
		<input type="checkbox"/> Yes <input type="checkbox"/> No		- -		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other
		<input type="checkbox"/> Yes <input type="checkbox"/> No		- -		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other
		<input type="checkbox"/> Yes <input type="checkbox"/> No		- -		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other
		<input type="checkbox"/> Yes <input type="checkbox"/> No		- -		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other

If you need to write about more children, use another piece of paper ** Race/Ethnicity Codes: B-Black S-Hispanic W-White I-Native American Indian/Alaska Native A-Asian/Pacific Islander O-Other
 ▶ Is anyone listed above pregnant? Yes No If yes, write name (s) and due date (s): _____ Does anyone have unpaid medical bills for the last 3 months? Yes No If yes, please write name(s), see instructions: _____

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

Name of person receiving income, including children ■ Proof is required, see Instructions	Employer Name ■ If self-employed write "self-employed"; or ■ If owner, write "owner"	Employer telephone number	Date job started	Full-time or Part-time?		How often paid?				Work income before taxes per pay period Amount	Other income such as child support, alimony, cash support, social security benefits, unemployment, rental income, etc.		If this person PAYS for day care for a child or disabled adult, list monthly amount	If this person PAYS child support or alimony, list monthly amount
				FT	PT	Every Week	Every 2 Weeks	2 Times a Month	Once a Month		Indicate Type of Income	Monthly Amount		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$	\$	\$

▶ Do any of the employers listed above offer health insurance? Yes No If yes, please list the Employer Name: _____ Employer address: _____
 ▶ Has anyone listed changed jobs in the last six months? Yes No If yes, please list Name _____ Former employer: _____ Date job ended: _____

3. HMO SELECTION: You must pick an HMO to be enrolled. Please see HMO flyer for available HMOs.

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

Jon S. Corzine
Governor
State of New Jersey

By signing this form, I represent that I have read and understood the Privacy Notice and the NJ FamilyCare program "Rights and Responsibilities", and that I will obey the law and regulations of the program. I understand that I am giving the NJ FamilyCare program permission to release my medical records and those of any of my family members who enroll in the program, to the program's HMOs and its providers. I also authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare program. In addition, I hereby authorize any educational institutions or school district to release my medical records or those of my child(ren) to the NJ FamilyCare program for the purpose of determining eligibility and billing the Program. I certify under penalty of law that everything on this application is true.

Sign your name here: _____ Date: _____

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

**Complete ONE application per family.
DO NOT LEAVE ANY SPACES BLANK.
PRINT CLEARLY.**

Instructions for Completing the NJ FamilyCare Application

Section 1

Household Information:

- **Address:**
List your home address.
If your mailing address is different from your home address, also write your mailing address in the space provided.
- **Telephone Numbers:**
Write your home telephone, cell phone numbers or another telephone number where we can reach you. Include area codes.
We must have a way to reach you.

List all Parents/Guardians and all children under the age of 21 living in household:

- **Name:**
The first adult listed will be considered the head of the household. It is important to list both parents, stepparents or guardians of the children, if they are living in the household. It is not necessary to list other adults who live in the household.
- **Social Security Number (SS#):**
You must provide a SS# for each person applying for NJ FamilyCare. Parents of newborns must supply the SS# as soon as it is available.
- **Race/Ethnicity:**
 - If your child is a Native American Indian or Alaskan Native, please submit his/her tribal card.
- **Citizenship: To be eligible for NJ FamilyCare, applicants must be a US citizen or qualified immigrant admitted for permanent residence.**
 - If you checked "yes", send any available documentation which proves the person requesting NJ FamilyCare is a U.S. citizen.
 - If you checked "no", you *must* send proof of immigration status.
Examples of acceptable proof include:
 - The front and back of a Resident Alien Card
 - The Temporary I-551 stamp on a passport or Form I-94
 - Documentation indicating refugee or asylee status.
 - Documentation indicating a parent's US military service.
- **Health Insurance:**
 - If you checked "yes", you must send a copy of the front and back of the insurance card with the application. **Note: You may still qualify for NJ FamilyCare even if you have other insurance.**
 - **Health Insurance within the last 3-months:**
 - If you checked "yes", you must send proof that the insurance was terminated.
- **Relationship:**
List how each child is related to the 1st and 2nd parents/guardians listed in Section 1. An example of "Other" would be a niece, nephew or grandchild.
- **Unpaid medical bills:**
 - If you checked "yes", submit proof of all household income for the last three months.

Section 2

Income Information for parents/guardians and children under 21:

- **Name of person receiving income:**
It is important to include the names of all parents, stepparents, guardians and children between the ages of 16-20 in the household who are working.
- **Employer Name:**
List **all** jobs and employers for each working person in the household.
 - If you are self-employed or the owner of a business, you must submit a **signed** copy of your last 1040 (including Schedule C, Form S1120, Form 1065, Schedule E, and all the other related schedules) or your last profit and loss statement.
- **Full-time or Part-time:**
Part-time employment is less than 30 hours per week.
- **Work income per pay period before deductions:**
 - Send in one check stub that best shows your pay or other proof showing **gross** income (before deductions) for the most recent month. **Be sure to send copies of check stubs for every job listed for each working person.**
- **Other Income (not from work):**
Indicate the **type** of other income such as:
 - Supplemental Security Income (SSI);
 - Social Security survivors/retirement;
 - Social Security disability benefits;
- **Other income types (continued):**
 - Veteran's benefits;
 - Unemployment;
 - State disability;
 - Workers' compensation;
 - Pension or annuity;
 - Interest or dividends;
 - Alimony you receive*;
 - Child support you receive*;
 - Cash from friends or family*;
 - Income from rent (not what you pay); and
 - All other income.
 - Send in copies of check stubs from the most recent month, award letters, or some proof of each kind of income received.
- ***No proof required**

Section 3

HMO Selection:

For you and your child(ren) to be enrolled in NJ FamilyCare, you must pick an HMO

- **Choose an HMO:**
See the HMO flyer in the application package for HMOs in your county.
- **Who is your Doctor?**
If you or your child(ren) see a doctor, please list his or her name and address.
- **Signature:**
 - Read the Privacy Notice and the NJ FamilyCare Rights and Responsibilities prior to signing the application. Make sure you **SIGN** and **DATE** the application before sending it to NJ FamilyCare.

Remember to:

1. **Sign** the application.
2. **Send** proof of income (the most recent month) for each job and for all other income, including self-employment and rental income.
3. **Citizens:** **Send** documentation proving US citizenship for anyone applying for NJ FamilyCare.
Non-Citizens: **Send** a copy of the Resident Alien Card or other immigration documentation for anyone applying for NJ FamilyCare.
4. **Send** proof of any other health insurance, or the letter you received if your health insurance ended.

If you wish to contact NJ FamilyCare:

- ✓ **Call 1-800-701-0710**
(TTY 1-800-701-0720 for hearing impaired)
Mondays and Thursdays 8 a.m. to 8 p.m., and on Tuesdays, Wednesdays and Fridays 8 a.m. to 5 p.m.
We speak 150 languages.
- ✓ **Write to us:** NJ FamilyCare
P.O. Box 8367
Trenton, NJ 08650; or
- ✓ **Visit us online at:** www.njfamilycare.org

• Documentation must be sent.