

APPLICATION FOR JERSEY ASSISTANCE FOR COMMUNITY CAREGIVING (JACC)
DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS) - DIVISION OF AGING AND COMMUNITY SERVICES

1. LAST NAME	2. MAIDEN NAME	3. FIRST NAME	4. MI	5. SEX	6. DOB
7. STREET ADDRESS		8. CITY	9. ST	10. ZIP CODE	11. COUNTY
13. ARE YOU A FULL-TIME RESIDENT OF NEW JERSEY? Yes No		14. IF NOT, EXPLAIN			
15. SOCIAL SECURITY #	16. SPOUSE'S NAME & SOCIAL SECURITY #		17. ARE YOU A UNITED STATES CITIZEN? Yes No		18. IF NO, SUBMIT PROOF OF QUALIFIED ALIEN STATUS
19. DO YOU HAVE / HAVE YOU HAD A PAAD CARD? Yes No	20. IF YES; WHAT IS/WAS YOUR PAAD ELIGIBILITY NUMBER?		21. ARE YOU 60 YEARS OF AGE OR OLDER? Yes No		22. SUBMIT 1 PROOF OF AGE
23. MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED	24. HAS THIS CHANGED IN THE PAST YEAR? YES NO If so, when?		25. DID YOU AND/OR YOUR SPOUSE FILE A FEDERAL, STATE, OR CITY INCOME TAX RETURN LAST YEAR? Yes No		26. IF YES, SUBMIT SIGNED COPIES ALONG WITH ANY SCHEDULES
27. DO YOU OWN ANY REAL ESTATE OTHER THAN YOUR HOME? Yes No	28. IF YES, DESCRIBE, GIVE LOCATION AND ESTIMATED EQUITY VALUE				
29. DO YOU HAVE HEALTH INSURANCE COVERAGE IN ADDITION TO MEDICARE? Yes No	30. IF YES, IDENTIFY THE PLAN OR COMPANY			31. PLEASE INDICATE IF THIS HEALTH INSURANCE IS: <input type="checkbox"/> MAJOR MEDICAL <input type="checkbox"/> MEDICARE SUPPLEMENT <input type="checkbox"/> OTHER: _____	
32. IF PROVIDED THROUGH AN EMPLOYER, PLEASE IDENTIFY THE EMPLOYER OR UNION.					
33. THE AMOUNT OF YOUR MOST RECENT SOCIAL SECURITY CHECK:			34. THE AMOUNT OF YOUR SPOUSE'S MOST RECENT SOCIAL SECURITY CHECK:		
35. DO YOU OR YOUR SPOUSE RECEIVE A PENSION OR SALARY? Yes No	36. IF YES, LIST THE NAME AND ADDRESS OF THE COMPANY, EMPLOYER, OR UNION.				

37. SOURCES OF INCOME: IF MORE SPACE IS REQUIRED, USED ADDITIONAL SHEETS. LIST YEARLY AMOUNTS	LIST ALL INCOME RECEIVED THE PREVIOUS CALENDAR YEAR*		LIST THAT INCOME ANTICIPATED FOR THE CURRENT CALENDAR YEAR *		*NOTE: DO NOT LEAVE BLANKS. INSERT "0" IF NONE APPLIES. DO NOT LIST CENTS.	
	PREVIOUS YEAR ACTUAL		CURRENT YEAR ANTICIPATED		OFFICE USE ONLY	
	YOU	SPOUSE	YOU	SPOUSE	A	S
SOCIAL SECURITY BENEFITS (NET)						
PENSION BENEFITS (SEE QUESTIONS 35 & 36)						
EARNINGS, SALARIES, TIPS (BEFORE DEDUCTIONS)						
UNEMPLOYMENT BENEFITS						
INTEREST & DIVIDENDS ON ALL ACCOUNTS						
RENTAL INCOME (NET AFTER EXPENSES)						
ALL OTHER INCOME (SPECIFY TYPE)						
TOTAL ANNUAL INCOME						

38. LIQUID RESOURCES: PLEASE LIST AND DESCRIBE ANY LIQUID RESOURCES HELD BY YOU OR YOUR SPOUSE JOINTLY OR INDIVIDUALLY IN YOUR NAME OR IN WHICH YOU HAVE A LEGAL INTEREST. GIVE NAME OF THE RESOURCE AND THE VALUE OF THE RESOURCE.

RESOURCE TYPE	RESOURCE NAME	ACCOUNT NUMBER	PRINCIPAL	PROOF REQ'D
SAVINGS ACCOUNT				
CHECKING ACCOUNT				
CERTIFICATES OF DEPOSIT				
STOCKS				
BONDS				
MUTUAL FUNDS				
MONEY MARKET FUNDS				
TRUSTS				
ANNUITIES				
SAVINGS BONDS				
TREASURY NOTES, BILLS, BONDS				
OTHER				
OTHER				

THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED.

1. I/WE CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND ACCURATE.
2. I/WE WILL NOTIFY JACC IMMEDIATELY OF THE FOLLOWING: ANY INCOME OR RESOURCE INCREASE ABOVE LEGAL LIMITS; A MOVE FROM NEW JERSEY; IF MEDICAID ELIGIBLE; IF DISABILITY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION (SSA) ARE HALTED; OR THE NATURE OF THE DISABILITY CHANGES.
3. I/WE UNDERSTAND THAT A VISIT BY REPRESENTATIVES OF JACC MAY OCCUR IN ORDER TO VERIFY ELIGIBILITY AND TO DETERMINE AVAILABILITY OF OTHER HOME CARE COVERAGE AND THAT SUCH VISITS ARE ACCEPTABLE.
4. I/WE AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO DETERMINE JACC ELIGIBILITY FROM THE RECORDS IN POSSESSION OF THE SSA, INTERNAL REVENUE SERVICE AND THE NEW JERSEY DIVISION OF TAXATION, EMPLOYER, BANKS, AND OTHERS AS THE NEED ARISES.
5. I/WE ARE AWARE THAT THIS IS A CO-PAY PROGRAM AND NON-PAYMENT SHALL RESULT IN DISENROLLMENT FROM THE PROGRAM. I/WE ARE AWARE THAT IF MY/OUR CO-PAY COUNTABLE INCOME EXCEEDS 365% OF THE FEDERAL POVERTY LEVEL, THE, I/WE WILL BE DISENROLLED FROM THE PROGRAM. I/WE UNDERSTAND THAT CO-PAY COLLECTION WILL NOT BEGIN UNTIL THE MONTH FOLLOWING FINAL DETERMINATION OF ELIGIBILITY.
6. I/WE REQUEST TO BE DETERMINED PRESUMPTIVELY ELIGIBLE FOR JACC: YES NO
 I/WE UNDERSTAND THIS MEANS THAT I/WE WILL RECEIVE BENEFITS PENDING A FINAL DETERMINATION OF ELIGIBILITY. I/WE UNDERSTAND THAT A FINAL DETERMINATION WILL BE MADE UPON SUBMISSION OF ANY DOCUMENTATION REQUIRED AS NOTED ON PAGE 4 OF THIS APPLICATION. I AGREE TO SUPPLY THE DOCUMENTATION WITHIN 14 DAYS OF THIS APPLICATION DATE. BASED ON ITS FORMAL REVIEW, THE DHSS MAY REQUIRE ADDITIONAL INFORMATION OR DOCUMENTATION, AND I/WE AGREE TO SUPPLY ANY ADDITIONAL REQUESTED INFORMATION WITHIN THE TIMEFRAMES REQUIRED. I/WE UNDERSTAND THAT IF ANY REQUIRED DOCUMENTATION IS NOT SUPPLIED WITHIN THE REQUIRED TIME FRAME, THE APPLICATION WILL BE AUTOMATICALLY WITHDRAWN AND BENEFITS DISCONTINUED. IF FOUND INELIGIBLE, I/WE UNDERSTAND THAT BENEFITS RECEIVED IN THE JACC PROGRAM WILL BE DISCONTINUED AND I/WE WILL BE DISENROLLED FROM THE PROGRAM. I/WE AGREE TO BE BOUND BY THE TERMS OF THE PARTICIPANT ENROLLMENT AGREEMENT DURING THE PRESUMPTIVE ELIGIBILITY PERIOD AND IF FOUND ELIGIBLE, THROUGHOUT THE DURATION OF ENROLLMENT IN THE PROGRAM.

SIGNATURE OF APPLICANT		DATE
SIGNATURE OF SPOUSE		DATE
APPLICANT TELEPHONE	()	
SIGNATURE OF PREPARER		Telephone ()
PERSON TO CONTACT FOR QUESTIONS		Telephone ()

REQUIRED DOCUMENTATION:

Please fill out the application and return along with copies of the following documents (if applicable):

- Proof of Residence
- Proof of Age
- Social Security Award Letter/ 1099's/ Bank Statement showing Deposit
- Most recent Checking Account Statement
- Most recent Savings Account Statement
- Proof of Pension
- Last Year's Tax Returns
- Savings/ Stocks/ Bonds/ Mutual Funds/ CD's/ Other Sources of Income
- Real Estate Information (other than your home)
- PAAD Card
- Health Insurance Coverage in addition to Medicare
- Proof of Alien Status

Mail completed application and required documentation to:

Morris County Division on Aging, PO Box 900, Morristown, NJ 07963-0900

Or fax completed application and required documentation to: (973) 285-6883

If you need further information or have any questions please contact our office at (800) 564-4656.

EXAMPLES OF PROOF OF RESIDENCE
(PROVIDE 1):

Driver's License

Social Security Form #2458 or Third Party Query Form (TPQY)

Landlord's rent records and receipts

Public utility records and receipts - e.g. phone bill, electric bill, etc.

Personal property assessment records

Bills of business or professional people - e.g. doctors, department stores, etc.

Post office records

Records of social agencies, public or private

Employment records

NOTE: Seasonal or temporary residence in New Jersey of what ever duration does not constitute residence. The residency requirement states that you must be a resident of New Jersey at least 30 days prior to the date of the application.

EXAMPLES OF PROOF OF AGE
(PROVIDE 1):

Birth Certificate

Baptismal certificate

Railroad retirement letter

Bris Certificate

SS Form #2458 or Third Party Query Form (TPQY)

Insurance policy

Drivers License

School Record

State or federal census record

Bible or other family record

Church record of baptism

Confirmation certificate

Marriage record

Employment record

Union record

Voting record

Passport

SAMPLES OF "OTHER" INCOME:

Retirement benefits/Annuities

Disability Benefits

Realized capital gains

Royalties

Alimony payments

Business income (net)

Worker's Compensation

Inheritance

Death benefits received (net)

Income from awards, prizes, gaming