





STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES

CHRIS CHRISTIE  
GOVERNOR

KIM GUADAGNO  
LT. GOVERNOR

PO BOX 726  
TRENTON, NJ 08625-0726

Jennifer Velez  
COMMISSIONER

Dawn Apgar  
Deputy Commissioner

Applicant Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Applicant's Primary Address \_\_\_\_\_

Form Completed by \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Does Applicant have a Legal Guardian?  Yes\*  No

*\*If yes, please complete*

Name \_\_\_\_\_ Phone #: \_\_\_\_\_

Address \_\_\_\_\_

Relationship to individual \_\_\_\_\_

*\*Please provide a copy of the Guardianship Order with application.*

**1. APPLICANT RESIDENCY AND OCCUPATION INFORMATION**

Place of Birth (hospital, city, state or country if born outside U.S.)

\_\_\_\_\_

If born outside U.S., is Applicant a U.S. citizen?  Yes  No

If No, is Applicant a permanent alien resident?  Yes  No

If Applicant is 18 or older and has a legal guardian, is the legal guardian a permanent legal resident of New Jersey?  Yes  No  Has no legal guardian

Is Applicant currently receiving services from any agency in any state other than New Jersey?

Yes  No If yes:

\_\_\_\_\_  
Name of Agency Address Phone #

Is applicant currently receiving services from the NJ Department of Children and Families?

Yes  No



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Does Applicant Reside in a Residential Program?  Yes\*  No

*\*If yes, please complete*

Placement Type \_\_\_\_\_

Provider Name \_\_\_\_\_

Funding Source \_\_\_\_\_

Is Applicant Employed?  Yes\*  No

*\*If yes, please complete*

Employer Name \_\_\_\_\_

Position \_\_\_\_\_

Does Applicant Attend a Day Program or School?  Yes\*  No

*\*If yes, please complete*

Type of Program \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Program/School \_\_\_\_\_

Address \_\_\_\_\_

Are you currently under DVR services?  Yes  No

Has DVR assisted you with employment or day services?  Yes  No

Has DVR assisted you with employment or day services?  Yes  No

**2. APPLICANT INSURANCE AND BENEFIT INFORMATION**

Applicant's Medicaid Number \_\_\_\_\_

*(Note: This is not the number on your Medicaid card. Please call N.J. Medicaid at 800-356-1561 to obtain your Medicaid number.)*

Date of Medicaid Eligibility \_\_\_\_\_

If you do not have Medicaid, have you already applied for it?  Yes  No\*

*\*If you do not have Medicaid, are you willing to apply for it?  Yes  No*

*(Note: you will not be able to receive services without Medicaid.)*

Medicare?  Yes  No *If yes, Medicare Number* \_\_\_\_\_

Private Insurance?  Yes  No

*If yes,*

Policy Name

Policy Number

Telephone Number

Social Security Administration Death or Disability (SSA/SSDI) benefits?  Yes  No

*If yes:* Claim # \_\_\_\_\_ Amount received per month: \$ \_\_\_\_\_

*If no:*  Never applied  Application pending  Ineligible



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Supplemental Security Income (SSI) benefits? \_\_\_\_\_ Yes \_\_\_\_\_ No  
*If yes, please complete*  
Claim # \_\_\_\_\_ Amount received per month: \$ \_\_\_\_\_

*If no, please complete*  
\_\_\_\_\_ Never applied \_\_\_\_\_ Application pending \_\_\_\_\_ Ineligible

If Applicant receives SSA/SSDI or SSI, is there a Representative Payee? \_\_\_\_\_ Yes\* \_\_\_\_\_ No  
*\*If yes, please complete*

	<u>Benefit</u>	<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
#1	_____	_____	_____	_____	_____
#2	_____	_____	_____	_____	_____

**3. APPLICANT FAMILY AND HOUSEHOLD INFORMATION**

Father: \_\_\_\_\_ Living \_\_\_\_\_ Deceased

*If living, please complete the following*  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address, if different from Applicant \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Social Security # \_\_\_\_\_ Veteran? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Marital Status \_\_\_\_\_ Is Father an Emergency Contact? \_\_\_\_\_ Yes \_\_\_\_\_ No

Mother: \_\_\_\_\_ Living \_\_\_\_\_ Deceased

*If living, please complete the following*  
Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address, if different from Applicant \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Social Security # \_\_\_\_\_ Veteran? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Marital Status \_\_\_\_\_  
Marital Status/Maiden Name: \_\_\_\_\_ Is Mother an Emergency Contact? \_\_\_\_\_ Yes \_\_\_\_\_ No

Other Members of Applicants Household (Do not include parents if they are listed above)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_