New Jersey Department of Health
Special Child Health Services - Family Centered Care Services
PO Box 364
Trenton, NJ 08625

SOCIO-ECONOMIC STATEMENT

1. Child Information			
Name of Child (Last, First)			**Telephone No.** (include area code)
Street Address			**Date of Birth**
City	**County**	**Zip Code**	**Petitioner (Parent or Guardian)**
Place of Birth	**Citizen** Yes ☐ No ☐		**Primary Language Spoken in Home**

2. List all family and relatives living with or contributing to family support:

Name	**Date of Birth**	**Occupation**	**Contributing to Family Support**	
			Yes	**No**
Parent 1			☐	☐
Parent 2			☐	☐
Relatives Living with Family			☐	☐
			☐	☐
			☐	☐
			☐	☐

3. Children

Name	**Date of Birth**	**Name**	**Date of Birth**

4. Parent or Guardian's place of residence during past year:

Street Address	**City**	**County**	**From (Mo/Yr)**	**To (Mo/Yr)**

SOCIO-ECONOMIC STATEMENT
(Continued)

5. List health insurance and/or drug plans (include primary & secondary)	
Name of Insurance Company	**Policy Holder**

*If Medicaid, include Medical Health Service Case Number.

*If NJFamilyCare, include plan A, B, C, or D.

6. Monthly Income (gross): (include savings accounts, Social Security, trusts, rental income, survivor's benefits, etc.)			
_____	_____	Parent 1 $_____	Other $_____
_____	_____	Parent 2 $ _____	Total $ _____
_____	_____	Source of Income Verification: _____	
7. Other Sources of Income:			
a. Child Support $ _____		Other $ _____	
b. Alimony **$** _____		Total $ _____	
Explain: _____			
7. Parent or Guardian Signature			
Signature of Petitioner:		**Date:**	