CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PO BOX 726
TRENTON, NJ 08625-0726

Jennifer Velez
COMMISSIONER

Dawn Apgar
Deputy Commissioner

Eligibility Documentation Checklist
Please complete the following forms as directed

Please Note: Individuals must be 18 years old to go through a functional evaluation for services. Individuals who meet functional criteria must also be 21 years old and Medicaid eligible before they can begin receiving services from the Division of Developmental Disabilities (DDD).

A. **DDD Eligibility Forms**:

- **Application for Eligibility.** The person completing the application must sign this form.
- **Health Information and Portability and Accountability Act (HIPAA) information**
  - i. **Notice of Privacy Practices and Acknowledgement Form.** Please read the Department of Human Services *Notice of Privacy Practices* and sign and return the *Acknowledgement Form*.
  - ii. **Authorization for Disclosure of Health Information to Family and Involved Persons.** Gives DDD permission to talk with people the Applicant chooses about his or her health information. Complete, sign and return.
  - iii. **Authorization for the Release of Health Information.** Gives DDD permission to send copies of Applicant's health records to people or organizations chosen by the Applicant. Complete, sign and return.

Consent Form. For use with the documents in Section B

You must include as many of the available documents below that relate to your developmental disability. The more documentation you are able to provide, the easier it will be to process your application.

B. Documentation of Developmental Disability

_____ Medical Documentation of Disability
_____ Physician's Statement
_____ Most Recent Psychological Evaluation, (+ IQ Scores)
_____ All Available Psychological Reports
_____ Most Recent Child Study Team or School Reports
_____ Learning Evaluations/Social Summaries
_____ Psychiatric Evaluation
_____ Neurological Evaluation
_____ Hospital Records/Discharge Summary
_____ Physical Therapy Evaluation/Occupational Therapy Evaluation/Speech Therapy Evaluation

C. Legal Documentation of Age, US Citizenship, NJ Residency

_____ Photocopy of Birth Certificate
_____ Photocopy of Social Security Card *or* Proof of US Citizenship *or* Green Card
_____ Photocopy of one of the following: 1) Voter Registration form 2) Pay Stub 3) W2 form 4) Real Estate Tax Bill or 5) Permanent Change of Station Orders to New Jersey (If individual's legal guardian is in the U.S. Military Service)

D. Other Necessary Documents:

_____ Photocopy of Guardianship Order (if applicable)
_____ Photocopy of Medicaid Card
_____ Letter certifying Medicaid eligibility
_____ SSI annual award letter
_____ Division of Vocational Rehabilitation Service (DVRS) Records/Evaluations (F3 form)

E. NJ CAT Assessment: Will be administered by the Developmental Disabilities Planning Institute (DDPI) at a later date.

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Application for Eligibility

Please Note: Individuals must be 18 years old to go through a functional evaluation for services. Individuals who meet functional criteria must also be 21 years old and Medicaid eligible before they can begin receiving services from the Division of Developmental Disabilities (DDD).

In accordance with the Revised Statute, State of New Jersey, Section 30:4-25.2, application is being made to the Commissioner of the Department of Human Services for a determination of eligibility for services provided through DDD for:

Name: _____
First Middle Last

Date of Birth _____/_____/_____

By signing this application, I am declaring that:

1. This Application and all forms submitted along with it are completed as accurately as possible, and
2. I understand that I have the opportunity to appeal a determination of ineligibility in accordance with N.J.A.C. 10:48-1.1(j).

This application is being made under *R.S.* 30:4-25.2 by virtue of the relationship to the Applicant indicated above:

____ Self

____ Legal Guardian of the person _____ Court of Competent Jurisdiction

Signature or Mark _____ Date: _____

Signature of Witness (if mark) _____

Printed Name of Witness (if mark) _____

Title if Agency or Court representative _____

Do Not Write Below This Line – for DDD use only

_____ Functional Criteria Met **_____Functional Criteria not met**

Eligible for Medicaid Yes_____ No_____ **Closed due to insufficient information_____**

_____ _____ _____

DDD Representative Signature **Title/Discipline** **Date**

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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? ____No _____ Yes*

**If yes, please complete the below and provide a copy of the Guardianship Order with the application.*
Name _____ Phone #:_____
Address _____
Relationship to individual _____

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 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 If yes, specify which services:

_____

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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 planning 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*

Benefit	**Name**	**Address**	**Phone**	**Relationship**
#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 _____

State of New Jersey - Department of Human Services
Notice of Privacy Practices
Effective date April 14, 2003

****Please Note: YOUR BENEFITS OR ELIGIBILITY WILL NOT BE AFFECTED BY THIS NOTICE.****
This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services.
Protected health information excludes individually identifiable health information in Education Records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

OUR RESPONSIBILITIES: The Department of Human Services is required by law to:
• Maintain the privacy of your health information
• Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
In addition, the Department of Human Services is required to:
• Abide by the terms of this notice
• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
• Notify you if we are unable to agree to a requested restriction.
We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will provide you with a revised notice.

GENERAL PRIVACY RULE
We will not use or disclose your health information without your written authorization, except as described in this notice.

Revoking Your Authorization: If you provide us with a written authorization to release your health information, you may revoke that authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

Separate Authorization for Psychotherapy Notes: We will not release any psychotherapy notes about you without a separate written authorization from you. You may revoke your specific written authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. **Treatment.** We may use your health information for your treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information with other health care professionals who are either part of the Department of Human Services or who are outside of the Department of Human Services to determine how to diagnose or treat you.

2. **Payment.** We may use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

3. **Health care operations.** We may use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

4. **Business Associates.** There are some services provided in our organization through contracts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require that the business associates appropriately safeguard your information.

5. **Facility Directory.** If you do not object, we may include your name, location within our facility, and general condition in our facility directory while you are at the facility. This information would only be disclosed to people who ask for you by name. In addition, unless you object, we may include your religious affiliation to disclose only to clergy members and will disclose that information even if the clergy member does not ask for you by name.

6. **Family and Friends Involved in Your Care.** If you do not object, we may share your health information with a family member, a relative or close personal friend who is involved in your care or payment related to your care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us to notify those persons.

7. **Research.** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

8. **Funeral directors.** We may disclose health information to funeral directors and coroners to carry out their duties consistent with applicable law.

9. **Organ procurement organizations.** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking of organs, or transplantation of organs for the purpose of tissue donation and transplant.
10. **Contacts.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

11. **Food and Drug Administration (FDA).** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

12. **Workers compensation.** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

13. **Public Health.** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

14. **Correctional institution.** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

15. **Law enforcement.** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

16. **Abuse, Neglect or Domestic Violence.** We may disclose your health information to the extent provided by law to an authority, social service agency or protective services agency if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will notify you of this disclosure promptly unless it would place you at risk of serious harm.

17. **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law such as audits, civil administrative or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for oversight of the health care system, government benefit programs, government regulated programs, or compliance with civil rights laws.

18. **Judicial and Administrative Proceedings.** We may disclose your health information in response to an order of a court or administrative tribunal, or in response to a valid subpoena if we receive satisfactory assurances from the party seeking the information that the party has made an attempt to notify you or to secure a protective order for your information.

19. **National Security and Intelligence Activities.** We may disclose your health information to authorized federal officials for national security activities.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the following rights:

• You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Department's general health care operations, and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing to the privacy officer.
Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it.

• You have the right to receive confidential communications of your health information. If you are dissatisfied with the manner in which or location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing, and submitted to the privacy officer. We will accommodate all reasonable requests.

• You may request to inspect and/or obtain copies of health information about you, which will be provided to you within 30 days. Such requests must be made in writing to the privacy officer. If you request to receive a copy, you may be charged a reasonable fee.

• If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information.
You must provide a reason to support your request. Such requests must be made in writing to the privacy officer.

• You may request that we provide you with a written accounting of all disclosures made by us of your health information for up to a six-year period of time; however, disclosures made prior to April 14, 2003, do not have to be accounted for by law. We ask that such requests be made in writing to the privacy officer.

Please note that an accounting will not include the following types of disclosures: disclosures made for treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures authorized by you or your legal representative; disclosures to correctional institutions or law enforcement officials or for national security purposes; disclosures made from the directory; and disclosures that are incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by).
There is no charge for the first request for an accounting made in any twelve-month period, but there may be a reasonable charge for additional requests in the same twelve-month period.

• You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

• You may revoke any authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing to the privacy officer.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the appropriate privacy officer listed on the attached sheets.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing to the Department's Privacy officer. The complaint form may be obtained from the Department's Privacy Officer and when completed should be returned to State of New Jersey, Department of Human Services PO Box 700, Trenton, NJ 08625. You may also file a complaint with the Secretary of the federal Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington DC 20201. This needs to be done within 180 days of when the problem happened. You can also complain to the Office of Civil Rights by calling 866-627-7748.

If you make a complaint to the Department's Privacy Officer or to the Secretary of Health and Human Services, there will be no retaliation against you and your benefits will not be affected.

New Jersey Department of Human Services
Division of Developmental Disabilities

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This form must be signed upon receipt of the Notice of Privacy Practices and returned to the New Jersey Division of Developmental Disabilities. If the Applicant is under 18, a Parent or the Legal Guardian must sign. If Applicant is 18 or older, Applicant or the Legal Guardian must sign.

I, _____ (print or type name),

hereby acknowledge that I have received the Notice of Privacy Practices

on_____.

I am the (please check one):

_____	_____	_____
Applicant	Parent (if applicant is under 18)	Legal Guardian

_____ _____

Applicant, parent or legal guardian signature or mark* Date

If signed by someone other than Applicant:

_____

Applicant Name (please print)

If mark is provided:

_____

Witness signature

_____

Witness Name (please print)

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name:_____

Date of Birth:_____

1. Person(s) authorized to use, disclose or receive information, include legal guardian, if applicable:

Primary Contact:	**Alternate Contact:**
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship:_____
Other Contact:	Other Contact:
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship:_____

Attach additional sheets if needed.

2. I am authorizing DDD staff to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization

3. I am authorizing the DDD staff to provide the minimum necessary health information to the individuals listed above and/or other individuals who are permitted to visit.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect ability to obtain treatment or payment or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.

7. The authorization expires on _____ or one year from the date of the individual's/legal guardian's signature.

8. A complete copy of this form will be maintained in the client record.

9. To Legal Guardians: If the individual receiving services is over the age of 18 and you have indicated that you are the Legal Guardian for this individual, you must attach a copy of Appointment of Guardianship to this form.

Signature (or mark) of
Individual or Legal Guardian:_____

Date of Signature:_____

Name of Legal Guardian* (if applicable):_____
*Copy of Valid Appointment of Guardianship must be attached.

If Mark is provided in place of signature, the mark must be witnessed:

Witness Signature (if applicable): _____

Witness Name/Title:_____

C: Case Manager - Original
Residential Program (if applicable)
Day Program (if applicable)

AUTHORIZATION FOR
THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
TO RELEASE RECORDS CONTAINING INDIVIDUALHEALTH INFORMATION

I hereby authorize _____ (facility/office) of the Division of Developmental Disabilities to disclose the individually identifiable health information as described below.

Name of Individual whose medical records are being requested:

_____

Name (*Please print*) Social Security Number Date of Birth

The medical records being requested were created between _____ and _____. A specific description of these records is provided below:

_____

_____

Purpose for which records will be used: _____

_____

☐ The records will be reviewed at the facility/agency.

☐ The records are to be copied. They will be picked up at the facility/office.

☐ The records being requested should be copied and sent to the person or organization and address below:

Name & address of person requesting records:

_____

_____

_____

Name & address of person(s) or organization(s) to receive the records <u>if other than person making request</u>:

_____

_____

_____

Telephone #:_____

Fax #_____

<u>Legal Authority for this request:</u>

☐ These are my records, and I am a legally competent adult.
☐ I am the legal guardian of the individual whose records are being requested, and I have attached a valid appointment of guardianship to this authorization.
☐ I am a parent of the individual whose records are being requested, and who is under the age of 18.
☐ I have Power of Attorney for the individual, and the Power of Attorney authorizes me to be able to request the individual's medical records, and a copy of the Power of Attorney is attached.

Understandings and Agreements about this Authorization:

1. This authorization is voluntary and I understand that DDD cannot condition treatment based on the signing of this authorization, unless the authorization is: (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.

2. This authorization will expire _____ (date to be determined by person signing this form) from the date of my signature below.

3. I understand that I may revoke this authorization at any time by notifying DDD in writing, but if I do, it will not have any effect on any actions taken prior to the time DDD received the revocation.

4. I agree to waive all claims against the DDD facility/agency for the release of the requested information.

5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by DDD if the recipient of the information is not a health plan, health care provider, healthcare clearinghouse, or a business associate that has a contract with DDD.

6. I understand that if I request that records be copied and sent to me, DDD will make a good faith effort to send those records to me in reasonable amount of time.

7. I understand that if I wish to have copies made of the records, DDD may assess a fee for copying the records.

***Signature (or mark) of Individual, Parent of Minor Child, Legal Guardian or person with Power of Attorney who is making this Request (please circle correct role)**:

_____

Date of Signature: **Telephone Number:**

_____ _____

_____ (Printed name of person making request)

***If a mark is provided in place of a signature, above, the mark must be witnessed:**

Witness Signature (if applicable):_____

Witness Name:_____

Witness Title:_____

***If person making request is a guardian or Power of Attorney, a copy of Valid Appointment of Guardianship or Power of Attorney must be attached.**

Consent to Release Information
To the
Division of Developmental Disabilities

I, _____, do hereby grant permission for
(Individual, Parent of individual if under 18, Legal Guardian or Power of Attorney)

_____
(Name of individual, institution, agency or other holder of information to be released)

to release the report(s), evaluation(s), summaries or other information described below regarding _____'s application for eligibility for services provided through the N.J. Division of Developmental Disabilities.

Information to be released:

_____

_____

_____

_____

This information is to be released to:

_____, Intake Worker
N.J. Division of Developmental Disabilities_____
Address: _____
_____
_____

Signature or Mark: _____Date: _____

Signature of Witness (if mark): _____

Printed Name of Witness (if mark): _____

If other than Individual Named Above, Relationship: _____

Note: The information received through this release is subject to the confidentiality regulations of the Division and cannot be released outside the Division without written permission unless otherwise provided by N.J.A.C. 10:41 et seq.

Please fill out and print the completed form. ***YOU MUST SIGN YOUR NAME and then mail the form in order to be registered.***

New Jersey Voter Registration Application

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Please print clearly in ink. All information is required unless marked optional.

1 Check boxes that apply: ❑ New Registration ❑ Address Change ❑ Political Party Affiliation or Non-affiliation Change ❑ Name Change ❑ Signature Update

FOR OFFICIAL USE ONLY

2 Are you a U.S. Citizen? ❑ Yes ❑ No *(If No, DO NOT complete this form)*

Will you be 18 years of age by the next election? ❑ Yes ❑ No *(If No, DO NOT complete this form)*

Clerk

3 Last Name	First Name	Middle Name or Initial	Suffix *(ex. Jr., Sr., III)*

Registration #

4 Date of Birth

Office Time Stamp

5 NJ Driver's License Number or MVC Non-driver ID Number

If you DO NOT have a NJ Driver's License or MVC Non-Driver ID, provide the last 4 digits of your Social Security Number.

❑ "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."

	Apt.	Municipality	County	State	Zip Code
6 Home Address *(DO NOT use PO Box)*					
7 Mailing Address if different from above					
8 Last Address Registered to Vote *(DO NOT use PO Box)*					

❑ by mail
❑ in person

9 Former Name if Making Name Change

Day Phone Number *(Optional)*

10 Do you wish to declare a political party affiliation? *(Optional)*

❑ Yes, the party name is _____.
❑ No, I do not wish to be affiliated with any political party.

11 Gender
❑ Female
❑ Male

Declaration - I swear or affirm that:
- I am a U.S. Citizen
- I live at the above address
- I will be at least 18 years old on or before the next election
- I will have resided in the State and county at least 30 days before the next election
- I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws
- I understand that any false or fraudulent registration may subject me to a fine of up to $15,000, imprisonment up to 5 years, or both pursuant to R.S. 19:34-1

Signature: Sign or mark and date on line below

X _____

Date _____

If applicant is unable to complete this form, print the name and address of individual who completed this form.

Name _____ Date _____

Address _____

_____

Important Instructions for sections 5, 6 and 10

5) Registrants who are submitting this form by mail and are registering to vote for the first time: If you do not have any of the information required by section 5, or the information you provide cannot be verified, you will be asked to provide a COPY of a current and valid photo id, or a document with your name and current address on it to avoid having to provide identification at the polling place.

Note: *ID Numbers are Confidential and will not be released by any governmental agency. Any person who uses such numbers illegally shall be subject to criminal penalties.*

6) If you are homeless, you may complete section 6 by providing a contact point or the location where you spend most of your time.

10) You may declare a political affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. Completing section 10 is Optional and will not affect the acceptance of your voter registration application.

Need More Information? Check boxes below if you would like to receive more information about:

❑ voting by mail
❑ becoming a poll worker
❑ polling place accessibility
❑ voting if you have a disability, including visual impairment
❑ available election materials in this alternative language: _____

For further information visit **www.NJElections.org** or call toll-free **1-877-NJVOTER** (1-877-658-6837)

New Jersey
Voter Registration Information

You can register to vote if:

- You are a United States citizen
- You will be 18 years of age by the next election
- You will be a resident of the State and county 30 days before the election
- You are NOT currently serving a sentence, probation or parole because of a felony conviction

Registration Deadline: 21 days before an election

Your County Commissioner of Registration will notify you if your application is accepted.
If it is not accepted, you will be notified on how to complete and/or correct the application.

Questions? visit **www.NJElections.org** or call toll-free **1-877-NJVOTER** (1-877-658-6837)

1 FOLD

NO POSTAGE
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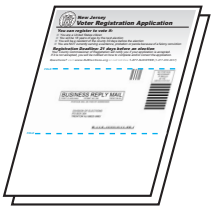
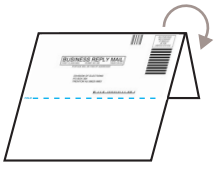
DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

2 FOLD

Important: Print out at 100% - DO NOT REDUCE. Fold as illustrated to ensure proper mailing.

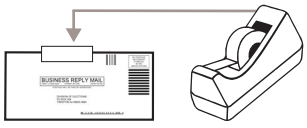


Put both pages together as shown



1 fold top down

2 fold bottom up



3 Tape top shut

3 TAPE HERE

Por favor llene e imprima la forma completada. USTED DEBE FIRMAR SU NOMBRE y luego envíe la forma a fin de ser registrado.

Nueva Jersey

76

Solicitud de Inscripción de Votantes

Escriba claramente con tinta. Se requiere toda la información a menos que esté marcada como opcional.

1 Marque las casillas que correspondan: ❑ Nueva inscripción ❑ Cambio de dirección ❑ Afiliación a partido político o Cambio de sin afiliación ❑ Cambio de nombre ❑ Actualización de la firma

Sólo para uso oficial

2 ¿Es ciudadano estadounidense? ❑ Sí ❑ No *(Si no lo es, NO complete este formulario)* ¿Tendrá 18 años de edad para la próxima elección? ❑ Sí ❑ No *(Si no es así, NO complete este formulario)*

Secretario

3 Apellido	Primer Nombre	Segundo nombre o Inicial	Sufijo(ej. Jr., Sr., III)

Núm. de inscripción

4 Fecha de nacimiento (Mes/Día/Año)

Timbre de hora de la oficina

5 Número de licencia de conducir de NJ o Número de identificación de MVC de no conductor

Si NO tiene una Licencia de conducir de NJ o Identificación de MVC de no conductor, indique los últimos 4 dígitos de su Número de Seguro Social.

❑ "Juro o afirmo que NO tengo una Licencia de conducir de NJ, Identificación de MVC como no conductor ni Número de Seguro Social."

	Apt.	Municipalidad	Condado	Estado	Código postal
6 Dirección del domicilio *(NO use apartados postales)*					
7 Dirección postal *si es diferente de la anterior*					
8 Última dirección registrada para votar (NO use apartados postales)					

❑ por correo ❑ en persona

9 Nombre anterior si hace un cambio de nombre

Número de teléfono durante el día *(Opcional)*

10 ¿Desea declarar una afiliación a un partido político? *(Opcional)*

❑ Sí, el nombre del partido es _____

❑ No, no deseo afiliarme a ningún partido político.

11 Sexo

❑ Femenino

❑ Masculino

Declaración - Juro y afirmo que:

- Soy ciudadano de los Estados Unidos
- Vivo en la dirección indicada
- Tendré por lo menos 18 años de edad para la próxima elección o antes
- Habré residido en el Estado y condado al menos 30 días antes de la próxima elección
- No estoy en libertad bajo palabra, libertad condicional ni cumpliendo una sentencia por haber sido condenado por un acto ilícito bajo las leyes federales o estatales
- Entiendo que cualquier inscripción falsa o fraudulenta puede someterme a una multa de hasta $15,000, pena de cárcel hasta 5 años o las dos cosas, conforme a R.S. 19:34-1

Firma: Firme o marque y fecha en la líneas a continuación

X _____

Fecha _____

Si el solicitante no puede completar este formulario, escriba el nombre y la dirección de la persona que completó este formulario.

Nombre _____ Fecha _____

Dirección _____

_____

Instrucciones importantes para las secciones 5, 6 y 10

5) A los votantes que presenten este formulario por correo y se inscriban para votar por primera vez: Si no tiene ninguna de la información requerida en la sección 5, o si no puede verificarse la información que indique, se le pedirá presentar una COPIA de una identificación actual con fotografía o un documento con su nombre y dirección actual incluida, para evitar tener que presentar identificación en la sede de votación.

Nota: *Los Números de identificación son confidenciales y no los comunicará ninguna entidad gubernamental. Cualquier persona que use dichos números ilegalmente quedará sujeta a sanciones penales.*

6) Si usted no tiene domicilio fijo, puede completar la sección 6 dando un punto de contacto o la ubicación donde pasa la mayor parte del tiempo.

10) Puede declarar una afiliación política o puede declarar no estar afiliado, sin importar ninguna afiliación anterior a un partido. Es OPCIONAL completar la sección 10 y no afectará la aceptación de su solicitud de inscripción de votante.

¿Necesita más información? Marque las casillas a continuación si desea recibir más información acerca de:

❑ votar por correo

❑ trabajar en los lugares de votación

❑ accesibilidad del lugar de votación

❑ votar si tiene alguna discapacidad, incluyendo problemas de visión

❑ materiales electorales disponibles en este otro idioma: _____

Para obtener más información visite **www.NJElections.org** o llame a la línea gratis **1-877-NJVOTER** (1-877-658-6837)

New Jersey
Información sobre la Inscripción de Elector

Puede inscribirse para votar si:

- Es ciudadano de los Estados Unidos
- Tendrá 18 años de edad para la siguiente elección
- Será residente del estado y condado 30 días antes de la elección
- Actualmente NO está sirviendo una sentencia, libertad bajo palabra o libertad condicional debido a una condena penal.

Fecha límite de la inscripción: 21 días antes de una elección

Su Comisionado de Registro del Condado le informará si se acepta su solicitud.
Si no se acepta, se le informará sobre cómo llenar y/o corregir la solicitud.

¿Preguntas? visite **www.NJElections.org** o llame sin cargo al **1-877-NJVOTER** (1-877-658-6837)

1 DOBLAR

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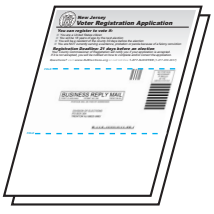
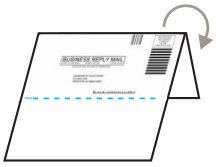
2 DOBLAR

Importante: Imprimir al 100% - SIN REDUCCIÓN. Doblar según se muestra para a segurar su envío apropiado en el correo postal.

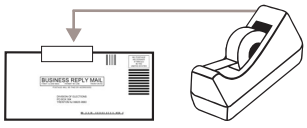


Junte las dos páginas como se muestra



1 doble la parte superior hacia abajo

2 doble la parte inferior hacia arriba



3 Ciérrelo con cinta adhesiva

3 PEGUE AQUÍ CON CINTA ADHESIVA