Applying for Services from the NJ Division of Developmental Disabilities

Application for Eligibility, including all signed forms and related documentation, must be mailed to the Community Services Office (CSO) that serves the Applicant’s county of residence (see page 2 for CSO locations and counties served).

- An individual must be 18 years of age or older to be evaluated by DDD for functional eligibility for services
- An individual must be 21 years of age or older and be Medicaid eligible to receive services from DDD

A. APPLICATION CHECKLIST

Any applicant who is 18 years of age or older and legally his/her own guardian must sign the required forms. If an applicant is receiving assistance completing the application, the person assisting should sign on the witness line.

☐ APPLICATION FOR ELIGIBILITY (5 pages)

☐ NOTICE OF PRIVACY PRACTICES (6 pages): please read and keep for applicant’s records

☐ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (1 page): after reading the Notice of Privacy Practices, sign and return with application

☐ AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS (2 pages): identifies people DDD can speak with regarding applicant’s health information – can include family members, health care professionals and emergency contacts; complete, sign and return with application

☐ AUTHORIZATION FOR RELEASE OF RECORDS (2 pages): gives permission to people/organizations chosen by the applicant to send copies of health records to DDD; complete, sign and return with application

☐ CONSENT FOR RELEASE OF INFORMATION TO DDD (1 page): for use with Section B documents – additional pages can be requested as needed; complete, sign and return with application

☐ NEW JERSEY VOTER REGISTRATION FORM (1 page): an individual can choose to register to vote if he/she is 18 years of age or older; a U.S. citizen; a resident of New Jersey; and not currently serving a sentence or on probation or parole. Complete, sign and return with application.

B. DOCUMENTATION OF DEVELOPMENTAL DISABILITY

Include as many of the available documents below as you are able that relate to the applicant’s developmental disability. The more documentation that is provided, the easier it is for DDD to process the application.

<table>
<thead>
<tr>
<th>Necessary</th>
<th>Helpful But Not Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Documentation of Disability</td>
<td>Most recent IEP</td>
</tr>
<tr>
<td>Most Recent Psychological Evaluation (+ IQ Scores)</td>
<td>Speech Therapy Evaluations</td>
</tr>
<tr>
<td>Neurological Evaluations</td>
<td>Occupational Therapy Evaluations</td>
</tr>
<tr>
<td>Most Recent Child Study Team or School Reports</td>
<td>Physical Therapy Evaluations</td>
</tr>
<tr>
<td>Psychiatric Evaluations</td>
<td>Hospital Records</td>
</tr>
<tr>
<td>DVRS Assessments</td>
<td>Social Summaries</td>
</tr>
<tr>
<td>All Available Psychological Reports</td>
<td></td>
</tr>
</tbody>
</table>
C. DOCUMENTATION OF MEDICAID ELIGIBILITY

Supplemental Security Income (SSI) annual award letter
Medicaid approval letter
Copy of Health Benefits Identification Card (“Medicaid” card)

If Applicant has encountered difficulty in obtaining Medicaid, contact DDD’s Medicaid Eligibility Helpdesk:
DDD.MediEligHelpdesk@dhs.state.nj.us

D. DOCUMENTATION OF AGE, US CITIZENSHIP, NJ RESIDENCY
(Note: applicant must be a permanent resident of New Jersey to apply for services through DDD)

1. Copy of Birth Certificate
2. Copy of Social Security Card or Proof of U.S. Citizenship or Green Card
3. Copy of one of the following:
   — Current Photo Identification from NJ Motor Vehicle Commission
   — Pay Stub
   — W2 Form
   — Real Estate Tax Bill
   — Permanent Change of Station Orders to New Jersey (if individual’s legal guardian is in the U.S. Military Service)
   — Voter Registration Form

E. OTHER DOCUMENTATION, if applicable

Copy of Guardianship Order
Division of Vocational Rehabilitation Services (DVRS) Records/Evaluations (F3 form)

F. NJ CAT ASSESSMENT

Once sections A-E have been provided to and reviewed by DDD, and all of the above information has been satisfied (up to and including face-to-face interview, if deemed appropriate by intake staff), the New Jersey Comprehensive Assessment Tool (NJ CAT) will be requested. The agency that administers the NJ CAT is the Developmental Disabilities Planning Institute (DDPI) at Rutgers.

DDD COMMUNITY SERVICES OFFICES

<table>
<thead>
<tr>
<th>Counties Served</th>
<th>Office Location and Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morris, Sussex, Warren</td>
<td>Flanders Office: 1 Laurel Drive Flanders, NJ 07836 Phone: 973.927.2600</td>
</tr>
<tr>
<td>Bergen, Hudson, Passaic</td>
<td>Paterson Office: 100 Hamilton Plaza, 7th Floor Paterson, NJ 07505 Phone: 973.977.4004</td>
</tr>
<tr>
<td>Essex</td>
<td>Newark Office: 153 Halsey St., 2nd FL, PO Box 47013, Newark, NJ 07101 Phone: 973.693.5080</td>
</tr>
<tr>
<td>Union, Somerset</td>
<td>Plainfield Office: 110 East 5th Street, Plainfield, NJ 07060 Phone: 908.226.7800</td>
</tr>
<tr>
<td>Ocean, Monmouth</td>
<td>Freehold Office: Juniper Plaza, Suite 1-J, 3499 Route 9 North, Freehold, NJ 07728 Phone: 732.863.4500</td>
</tr>
<tr>
<td>Hunterdon, Mercer, Middlesex</td>
<td>Trenton Office: 11A Quakerbridge Plaza, PO Box 705, Trenton, NJ 08619 Phone: 800.832.9173</td>
</tr>
<tr>
<td>Atlantic, Cape May, Cumberland, Salem</td>
<td>Mays Landing Office: 5218 Atlantic Avenue, Suite 205, Mays Landing, NJ 08330 Phone: 609.476.5200</td>
</tr>
<tr>
<td>Burlington, Camden, Gloucester</td>
<td>Voorhees Office: 2 Echelon Plaza, 221 Laurel Rd, Suite 210, Voorhees, NJ 08043 Phone: 856.770.5900</td>
</tr>
</tbody>
</table>

Applying for Services from NJ Division of Developmental Disabilities | December 2018
APPLICATION FOR ELIGIBILITY

The Application for Eligibility can be completed by an applicant who is 18 years of age or older, or by a guardian or representative acting on behalf of an applicant who is 18 years of age or older.

- Eligible individuals who are 21 years of age or older and on Medicaid can receive services from the Division of Developmental Disabilities (DDD)
- Eligible individuals who are 18 years of age but not yet 21 years of age can receive services from the NJ Department of Children and Families (DCF) Children’s System of Care (CSOC): 877.652.7624
- Individuals who are under 18 years of age can apply for and may be eligible to receive services from CSOC. For information about CSOC or to apply for services for an individual who is under 18, call 877.652.7624

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

Applicant Name: _____________________________________________

First    Middle     Last

Date of Birth: _____________________________________________

By signing this application, I am declaring that:

1. This Application for Eligibility and all forms submitted with it have been completed as accurately as possible.
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 (Applicant)    ☐ Legal Guardian of the Applicant    ☐ Court of Competent Jurisdiction

Applicant Signature or Mark: _____________________________________________ Date: ____________

Witness Signature: _____________________________________________ Date: ____________

Print Name of Witness: _____________________________________________

Title (if agency or court representative): ________________________________

FOR DDD USE ONLY – Applicant please continue to page 2

Functional Criteria Met ☐ Yes    ☐ No

Medicaid Eligible ☐ Yes    ☐ No

Closed due to Insufficient Information ☐ Yes    ☐ No

DDD Representative Signature Title/Discipline Date

DDD Representative Signature Title/Discipline Date
Applicant Information

Applicant Name: 

Date of Birth: 

Home Address: 

Phone Number: 

Email Address: 

Application Completed By (if not by completed by Applicant):

Name: 

Home Address: 

Phone Number: 

Email Address: 

Can DDD contact you, if necessary, regarding this application?  ☐ Yes  ☐ No

Does the applicant have a Legal Guardian?**  ☐ Yes  ☐ No

**If yes, please complete the section below and provide a copy of the Guardianship Order with the application

Legal Guardian Name: 

Relationship to Applicant: 

Address: 

Phone Number: 

Email Address: 

---

Application for Eligibility | NJ Division of Developmental Disabilities | December 2018  Page 2 of 5
(1) APPLICANT RESIDENCY AND OCCUPATION INFORMATION

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

If born outside of the U.S., is Applicant a U.S. Citizen?  □ Yes  □ No
If No, does Applicant have a valid Green Card?  □ Yes  □ No
If Applicant has a legal guardian, is the legal guardian a permanent legal resident of New Jersey?  □ Yes  □ No

Is Applicant currently receiving services from any other federal, state or local agencies?  □ Yes  □ No

Agency Name: _________________________________ Phone: _________________________________
Address: ____________________________________________
Agency Name: _________________________________ Phone: _________________________________
Address: ____________________________________________
Agency Name: _________________________________ Phone: _________________________________
Address: ____________________________________________
Agency Name: _________________________________ Phone: _________________________________
Address: ____________________________________________

Does Applicant live in a Residential Program?  □ Yes  □ No
(For example, DCF, DCPP, Boarding Home, Homeless Shelter)

Residence Name: _________________________________ Residence Type: _________________________________
Address: ____________________________________________

Does Applicant attend school or day program, and/or is Applicant employed?  □ Yes  □ No

Program Type: _________________________________ Name: _________________________________
Address: ____________________________________________
Contact Name and Phone Number: ____________________________________________
Program Type: _________________________________ Name: _________________________________
Address: ____________________________________________
Contact Name and Phone Number: ____________________________________________

Has the NJ Division of Vocational Rehabilitation Services (DVRS) assisted Applicant with employment or day services?  □ Yes  □ No
(2) APPLICANT MEDICAID AND SOCIAL SECURITY BENEFIT INFORMATION

Does Applicant have Medicaid? □ Yes □ No
If not, has Applicant applied for Medicaid? □ Yes □ No

(To receive services through DDD, Applicant must obtain Medicaid. If Applicant has encountered difficulty in obtaining Medicaid, contact DDD’s Medicaid Eligibility Helpdesk: DDD.MediEligHelpdesk@dhs.state.nj.us)

Does Applicant receive Social Security Disability Insurance (SSDI) benefits? □ Yes □ No
If yes, amount received per month: $ ______________________
If no, what is SSDI application status? □ Never Applied □ Application Pending □ Ineligible

Does Applicant receive Supplemental Security Income (SSI) benefits? □ Yes □ No
If yes, amount received per month: $ ______________________
If no, what is SSI application status? □ Never Applied □ Application Pending □ Ineligible

If Applicant receives SSDI or SSI, is there a Representative Payee? □ Yes □ No
Payee Name: ___________________________________________ Benefit Type: ______________________
Address: ___________________________________________ Phone: ______________________
Relationship to Applicant: ____________________________________________________________
Payee Name: ___________________________________________ Benefit Type: ______________________
Address: ___________________________________________ Phone: ______________________
Relationship to Applicant: ____________________________________________________________

(3) APPLICANT FAMILY AND HOUSEHOLD INFORMATION

Father: □ Living □ Deceased

If living, please complete the following:
Name: ___________________________________________ Date of Birth: ______________________
Address: ___________________________________________
Phone (Home): __________________ (Cell): __________________ (Work): __________________
Email Address: ___________________________________________
Marital Status: ___________________________________________
Is father a Veteran? □ Yes □ No
Is father an emergency contact? □ Yes □ No
Mother:  □ Living  □ Deceased  

If living, please complete the following:
Name:  ____________________________  Date of Birth:  ____________________________
Address:  _________________________________________________________
Phone (Home):  ____________________________  (Cell):  ____________________________  (Work):  ____________________________
Email Address:  __________________________________________________________
Marital Status:  ____________________________  Maiden Name, if applicable:  ____________________________
Is mother a Veteran?  □ Yes  □ No  Is mother an emergency contact?  □ Yes  □ No

Other Members of Applicant’s Household (do not include parents if they are listed above)
Name:  __________________________________________________________
Date of Birth:  ____________________________  Relationship:  ____________________________
Name:  __________________________________________________________
Date of Birth:  ____________________________  Relationship:  ____________________________
Name:  __________________________________________________________
Date of Birth:  ____________________________  Relationship:  ____________________________

NOTICE OF PRIVACY PRACTICES
Effective Date: October 15, 2018

This Notice applies to individuals receiving services from the Department of Human Services’ (DHS) Division of Developmental Disabilities and does not require your response. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

- **Right to see and copy your records.** In most cases, you have a right to view or get copies of your records. You must make your request in writing. We will provide a response to your request within thirty (30) days. You may be charged a fee for the cost of copying your records.

- **Right to an electronic copy of your medical records.** If your information is maintained in an electronic format, you may request that your electronic records be transmitted to you or another individual or entity. We will respond to your request within thirty (30) days.

- **Right to correct or update your records.** You may ask us to correct your health information if you think there is a mistake. You must make your request in writing and provide a reason for your need to correct the information.

- **Right to choose how we communicate with you.** You may ask us to share information with you in a certain way. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You don’t have to explain a reason for the request. We may deny unreasonable requests.

- **Right to get a list of disclosures.** You have a right to ask us for a list of disclosures made after April 14, 2003. You must make a request in writing. This will not include information shared for treatment, payment or health operation purposes. We will provide one accounting a year free of charge, but may charge a cost for additional lists provided within the 12 month period.

- **Right to get notice of a breach.** You have a right to be notified upon a breach of any of your protected health information.

- **Right to request restrictions on uses or disclosures.** You have a right to ask us to limit how your information is used or shared with others. You must make the request in writing and indicate what information should be limited. We are not required to agree to a requested restriction. If you paid out-of-pocket expenses in full for a specific item or...
service, you have a right to ask that your information with respect to that item or service not be disclosed. We will always honor that request.

*Right to revoke authorization.* If we ask you to sign an authorization to use or disclose your information, you can cancel that authorization at any time. You must make that request in writing. Your request will not affect information that has already been shared.

*Right to get a copy of this notice.* You have a right to ask for a paper copy of this notice at any time

*Right to file a complaint.* You have a right to file a complaint if you don’t agree with how we have used or disclosed your information.

*Right to choose someone to act for you.* If someone has been legally designated as your personal representative, that person can exercise your rights and make choices about your health.

**OUR DUTIES**

The Department of Human Services functions as a health care provider for you and your family. Consequently, we must collect information about you to provide these services. We are required to protect your information according to federal and state law and will abide by the terms of this notice. We may use and disclose information without your authorization for the following purposes:

*Treatment Purposes.* We may use or disclose your information to health care providers who are involved in your health care.

*Payment.* We may use or disclose your information to get payment or pay for health care services you received or will receive.

*Health Care Operations.* We may use or disclose your information in order to manage our business, improve your care and contact you when necessary.

*As Required by Law.* We will disclose information to a public health agency that maintains vital records, such as births, deaths and some diseases.

*Abuse and Neglect Investigations.* We may disclose your information to report all potential cases of abuse and/or neglect.

*Health Oversight Activities.* We may use or disclose your information to respond to an inspection or investigation by state officials.

*Government Programs.* We may use and disclose your information for the management and coordination of public benefits under government programs.

*To Avoid Harm.* We may use and disclose information to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.
• **For Research.** We may use and disclose your information for studies and to develop reports. These reports will not specifically identify you or another person.

• **Business Associates.** We may use and disclose your information to our business associates that perform functions on our behalf, if necessary to complete those functions.

• **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose your information to organizations engaged in procuring, banking or the transportation of organs, eyes, or other tissues to facilitate organ transplantation.

• **Military and Veterans.** If you are a member of the armed forces, we may disclose your information to the appropriate military authority.

• **Workers Compensation.** We may use or disclose your information for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

• **Data Breach Notification Purposes.** We may use or disclose your information to provide legally required notices of unauthorized access or disclosure of your health information.

• **Lawsuits and Disputes.** We may use or disclose your information in response to a Court or Administrative Order, subpoena, discovery request or other lawful process.

• **Law Enforcement.** We may disclose your information to law enforcement if the information: 1) is in response to a court order, subpoena, warrant or similar process; 2) limited to identify or locate a suspect, fugitive, material witness or missing person; 3) about a victim of a crime under very limited circumstances; 4) about a death potentially resulting from a crime; 5) about criminal conduct on any DHS property and; 6) is needed in an emergency to report a crime or facts surrounding a crime.

• **Coroner, Medical Examiners and Funeral Directors.** We may disclose your information to a Coroner or Medical Examiner to identify a deceased person or determine the cause of death. We may release your information to a Funeral Director as necessary for their duties.

• **National Security and Intelligence.** We may disclose your information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

• **Protective Services for the President and Others.** We may disclose your information to authorized federal officials so that they can provide protection to the U.S. President; other authorized persons or foreign heads of state, or to conduct special investigations.

• **Inmates or Individuals in Custody.** If you are an inmate, we may release your information to a correctional institution if that information would be necessary for the institution to: 1) provide you with health care; 2) protect your health and safety or the health and safety of others or: 3) for the safety and security of the correctional institutions.
• **Disclosure to Family, Friends and Others.** We may disclose your information to your family members, friends or other persons who are involved in your medical care. You may object to the sharing of this information. We may also share your information with someone legally designated as your personal representative.

• **Hospital Directory.** Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital.

**Other Uses and Disclosures that Require Your Written Authorization**

• **For All Other Situations.** We will ask for your written authorization before using or disclosing information for any other purpose than what is mentioned above. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes and for the sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, please contact us at the number below. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

• **As Required by Other Laws.** We will ask for your written authorization to comply with other laws protecting the use and disclosure of your information.

**FILING A COMPLAINT**

To file a complaint or report a problem regarding the use or disclosure of your health information, use the contact information below. Treatment or services being provided to you will not be affected by any complaints you make. DHS opposes retaliatory acts resulting from participation in a HIPAA investigation.

New Jersey Department of Human Services
Division of Developmental Disabilities
Legal and Administrative Practice Office
P.O. Box 726
222 South Warren St.
Trenton, NJ 08625-0726
Phone: 609-633-7402

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, S.W., Room 509H
Washington DC, 20201
Phone: 866-627-7748/TTY: 886-788-4989
[www.hhs.gov/ocr](http://www.hhs.gov/ocr)

DHS or its appropriate Division will respond to your communication within 30 days.

**CHANGES TO THIS NOTICE**

In the future, DHS may change its Notice of Privacy Practices. Any change could apply to medical information we already have about you, as well as information we receive in the future. A copy of a new notice will be posted in our facilities/offices and provided to you as required by law. You may ask for a copy of our current notice or get it online on our website.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This **ACKNOWLEDGEMENT OF RECEIPT** must be signed upon receipt of the Notice of Privacy Practices and returned to the New Jersey Division of Developmental Disabilities.

I, ____________________________________________________ (print name)

Hereby acknowledge that I received the **Notice of Privacy Practices** on __________________________ (date)

I am: *(please check one)*

☐ Applicant

☐ Parent

☐ Legal Guardian

_____________________________________________  ________________________________
Applicant, Parent or Legal Guardian Signature or Mark*  Date

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

_____________________________________________
Witness Signature, if applicable

_____________________________________________
Witness Name (please print)
New Jersey 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):  

<table>
<thead>
<tr>
<th>PRIMARY CONTACT</th>
<th>ALTERNATE CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Alternate Phone:</td>
<td>Alternative Phone:</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER CONTACT</th>
<th>OTHER CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Alternate Phone:</td>
<td>Alternative Phone:</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

2. I authorize 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 authorize DDD staff to provide the minimum necessary health information to the contacts 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 my 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 health care 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. This 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 applicant's record.

9. **To Legal Guardians:** If the individual receiving/applying for services is 18 years of age or older and you have indicated that you are the individual's Legal Guardian, then you must attach a copy of a valid [Appointment of Guardianship](#) to this form.

---

**Individual or Legal Guardian Signature or Mark**

---

**Legal Guardian Name, if applicable (please print)**

---

Please attach a valid Appointment of Guardianship to this form, if applicable

---

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

---

**Witness Signature, if applicable**

---

**Witness Name (please print)**
AUTHORIZATION FOR RELEASE OF RECORDS
CONTAINING INDIVIDUALLY IDENTIFIABLE HEALTH 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:

<table>
<thead>
<tr>
<th>Name (please print)</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

The requested medical records were created between _______________ and ________________.

Description of Requested Medical Records:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Purpose for which Medical Records will be used:

________________________________________________________________________

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

☐ The requested records are to be copied; they will be picked up at the DDD facility/office.

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

Name and Address of Person Requesting Records: ________________________________

Name and Address of Person/ Organization to Receive Records if other than the person making the request:

________________________________________________________________________

________________________________________________________________________

Phone: ____________________________

Fax: ____________________________
Legal Authority for this Request:

☐ These are my records, and I am a legally competent adult.

☐ I am the Legal Guardian of the individual whose records are being requested. A copy of valid Appointment of Guardianship is attached.

☐ I am a parent of the individual whose records are being requested and I have Power of Attorney for the individual, which authorizes me to be able to request the individual’s medical records. A copy of valid 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 use by/disclosure to a third party.
2. This authorization will expire on __________________ (date to be determined by person signing this form) or one year from the date of my signature below.
3. I understand I may revoke this authorization at any time by notifying DDD in writing, and my written revocation will not have any effect on any actions taken prior to the time DDD received the written revocation.
4. I agree to waive all claims against the DDD facility/agency for 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, health care clearinghouse, or 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 within a reasonable timeframe.
7. I understand that if I wish to have copies of the records made, DDD may assess a fee for copying the records.

______________________________
Signature (or mark*) of Individual, Legal Guardian or Power of Attorney (please circle one) making this Request

Date     Phone Number

Name of Person Making this Request (please print): ______________________________________________________

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

______________________________
Witness Signature, if applicable

______________________________
Witness Name (please print)

If Requestor is the Legal Guardian or Power of Attorney for the Individual, a copy of valid Appointment of Guardianship or Power of Attorney must be attached.
CONSENT FOR RELEASE OF INFORMATION
TO THE NJ DIVISION OF DEVELOPMENTAL DISABILITIES

I, ____________________________________________

(Individual, Legal Guardian or Power of Attorney Name)

Do hereby grant permission for ____________________________________________

(Name of individual, institution, agency, or other holder of requested information)

To release the report(s), evaluations(s), summaries or other information described below regarding the Application for Eligibility for services through the NJ Division of Developmental Disabilities of:

Applicant Name (please print): ____________________________________________

Information to be released:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Information is to be released to:

__________________________________________, Intake Worker

NJ Division of Developmental Disabilities

_____________________________________________________________________

_____________________________________________________________________

Signature or Mark*: ____________________________________________ Date: __________

If other than applicant, relationship to applicant: ____________________________________________

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

Witness Signature, if applicable: ____________________________________________

Witness Name (please print): ____________________________________________

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. 10:41et seq.
### New Jersey Voter Registration Application

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

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

2. **Are you a U.S. Citizen?**  
   - Yes  
   - No  

   *(If No, DO NOT complete this form)*

3. **Are you at least 17 years of age?**  
   - Yes  
   - No  

   *(If No, DO NOT complete this form)*

4. **Last Name**  
   - First Name  
   - Middle Name or Initial  
   - Suffix (Jr., Sr., III)

5. **Date of Birth**

6. **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.*

7. **Home Address (DO NOT use PO Box)**

8. **Mailing Address if different from above**

9. **Last Address Registered to Vote (DO NOT use PO Box)**

10. **Former Name if Making Name Change**
    - a. Day Phone Number (Optional)
    - b. E-mail Address (Optional)

11. **Do you wish to declare a political party affiliation?**
    - Yes, the party name is ___________________________.
    - No, I do not wish to be affiliated with any political party.

12. **Gender**
    - Female
    - Male

   **Declaration** - I swear or affirm that:  
   - I am a U.S. Citizen  
   - I live at the above address  
   - I am at least 17 years old, and understand that I may not vote until reaching the age of 18.  
   - 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

13. **Signature: Sign or mark and date on lines below**

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

   - Name ____________________________
   - Date ____________________________
   - Address ____________________________

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**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 party affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. If you are a previously affiliated voter who wants to change political party affiliation or become unaffiliated, you must file this form no later than 55 days before the primary election in order to vote in the primary election. 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
- [ ] polling place accessibility
- [ ] available election materials in
- [ ] becoming a poll worker
- [ ] voting if you have a disability,
- [ ] this alternative language:

For further information visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)
You can register to vote if:
- You are a United States citizen.
- You are at least 17 years of age.*
- 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.

*You may register to vote if you are at least 17 years old but cannot vote until reaching the age of 18.

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 Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)