APPLICATION FOR JERSEY ASSISTANCE FOR COMMUNITY CAREGIVING (JACC)
DEPARTMENT OF HUMAN SERVICES (DHS) - DIVISION OF AGING SERVICES (DOAS)

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	12. SUBMIT 1 PROOF OF RESIDENCE

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: ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ MARRIED ❑ 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: ❑ MAJOR MEDICAL ❑ MEDICARE SUPPLEMENT ❑ 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.	
SOURCE	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 UNITL THE MONTH FOLLOWING FINAL DETERMINATION OF ELIGIBILITY.		
6. I/WE REQUEST TO BE DETERMINED PRESUMPTIVELY ELIGIBLE FOR JACC:. __X_ 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 ( )