New Jersey Department of Health
Health Insurance Continuation Program
PO Box 363
Trenton, NJ 08625-0363

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (HICP)

Before you begin completing the application form, please take a few minutes to review these specific instructions. While many of the questions are self-explanatory, some require additional clarification to be completed correctly.

If you need assistance completing this application, call toll free 1-800-353-3232.

SECTION I - PATIENT INFORMATION

Question 2 - Providing your Social Security Number is mandatory for the processing of your application.

Question 3 - Enter your principal place of residence. The residency requirement states that you must be a resident of New Jersey for at least 30 days prior to the date of this application.

Include two (2) proofs of residency which are current and dated. The date must be clearly visible and no more than six (6) months old. Sample proofs of residency include but are not limited to:

Landlord's records and rent receipts
Public utility records and receipts (electric, gas, phone bill)
Bills of business or professional people (doctors, department stores)
Records of social agencies, public or private
Employment records

DOMESTIC STATUS:

Question 12 - Check "separated" if:
(1) You and your spouse/partner live apart **AND** if you do not have access to, or receive support from, your spouse's/partner's income; OR
(2) Your spouse/partner has been confined to a long-term care or psychiatric institution for at least 30 days prior to this application.

HOUSEHOLD SIZE:

Question 14 - In calculating the number of people in the household, include:
(1) Yourself, spouse/partner (if married/civil union), **AND**
(2) All persons whom you claim as dependent OR All persons who claim you, the applicant, as their dependent.

SECTION II – INFORMATION ON INSURED

Question 16 - Providing your Social Security Number is mandatory for the processing of your application.

SECTION III - INCOME AND ASSETS

Question 17 - Enter household income as requested. Also attach verification of income (i.e., pay stubs).
If you are married or a member of a civil union, enter your income **PLUS** your spouse's/partner's income.
If you are claimed as a dependent for income tax purposes, then provide proof of income for the claimant.

Fill in ALL of the blanks. List gross figures unless otherwise indicated. If your income for any category is zero, write "0" in that space.

Maximum allowable household income limits for this Program are:

Number of Persons in Household	Maximum Allowable Household Income
1	$54,450
2	73,550
3	92,650
4	111,750
5 or more	130,850

Maximum allowable cash assets per household is $25,000 (not including house or car).

Question 18 - Provide requested information on cash assets. Also attach verification of assets (i.e., bank statements).

SECTION VI - CERTIFICATION BY APPLICANT

The Certification must be dated and signed (or marked) by you, or legal guardian or the patient and by a witness (i.e., case manager).

HEALTH INSURANCE INFORMATION FORM (DHAS-39)

Questions 1 through 6 - Check all that apply regarding your health insurance coverage. If you have "Private Health Insurance" through any source, provide the policy number(s) as well as name and address of the insurance carrier(s). If this coverage is provided by an employer (current or previous) or union, enter the name and address of the employer or union. "Private Health Insurance" includes the health insurance provided by private insurance carriers such as Blue Cross/Blue Shield, HMO, PPO, etc.

CERTIFICATION BY PHYSICIAN FORM (DHAS-40)

Complete the requested information in Section I and forward to your physician for completion of Section II. Make sure that all requested information has been clearly entered. Ask your physician to return the completed form to you.

AUTHORIZATION/RELEASE OF INFORMATION FORM (DHAS-41)

Complete the requested forms and forward to the Health Insurance Continuation Program along with the completed Application.

CONFIDENTIALITY RELEASE FORM (DHAS-42)

Complete the requested forms and forward to the Health Insurance Continuation Program along with the completed Application.

BEFORE YOU MAIL YOUR APPLICATION:

REVIEW THIS CHECKLIST AND MAKE SURE THAT EACH OF THE FOLLOWING ITEMS IS MAILED WITH YOUR APPLICATION:

- ☐ APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (DHAS-31) (Completed and signed)
- ☐ TWO (2) PROOFS OF RESIDENCY
- ☐ VERIFICATION OF INCOME (pay stubs)
- ☐ INCOME TAX RETURN (most recent)
- ☐ VERIFICATION OF ASSETS (bank statements)
- ☐ HEALTH INSURANCE INFORMATION FORM (DHAS-39) (Completed and signed)
- ☐ ORIGINAL PREMIUM NOTICE WITH PREMIUM INFORMATION
- ☐ PHYSICIAN CERTIFICATION (DHAS-40) (Completed and signed)
- ☐ AUTHORIZATION/RELEASE OF INFORMATION (DHAS-41) (Completed and signed)
- ☐ CONFIDENTIALITY RELEASE (DHAS-42) (Completed and signed)
- ☐ DRIVER'S LICENSE (If licensed)
- ☐ COPY OF INSURANCE CARD

MAIL ABOVE ITEMS (COMPLETED APPLICATION) TO:

NEW JERSEY DEPARTMENT OF HEALTH
HEALTH INSURANCE CONTINUATION PROGRAM
PO BOX 363
TRENTON, NJ 08625-0363

New Jersey Department of Health
Health Insurance Continuation Program
PO Box 363
Trenton, NJ 08625-0363

FOR STATE USE ONLY
Record #

APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM

Please print clearly and answer all questions. Review the attached instructions before you begin. If you need assistance completing the application, call toll free 1-800-353-3232. Mail the completed application to the Health Insurance Continuation Program, at the address given above. Send copies of any requested documents. Do not send originals as they WILL NOT be returned.

1. DO YOU CURRENTLY HAVE HEALTH INSURANCE COVERAGE? ☐ **YES** ☐ **NO**

IF "YES," PLEASE COMPLETE THIS APPLICATION.

IF "NO," DO NOT CONTINUE SINCE YOU ARE NOT ELIGIBLE FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM.

2. DO YOU CURRENTLY HAVE MEDICATION COVERAGE BY THE AIDS DRUG DISTRIBUTION PROGRAM (ADDP)? ☐ **YES** ☐ **NO**

SECTION I - PATIENT INFORMATION

1. Patient Name (Last, First, MI)	2. Social Security Number ____ - ____ - ____
3. Street Address	4. Date of Birth ____ / ____ / ____
5. City, State, Zip Code	6. County

7. Residency

a. How long have you lived at the above address? ______ Years ______ Months

b. Is this your principal residence? ☐Yes ☐No

NOTE: TWO (2) PROOFS OF RESIDENCY MUST ACCOMPANY YOUR APPLICATION.

8. Sex	9. Race			10. Ethnicity
☐Male	☐White	☐Asian	☐Multiple Races	☐Hispanic/Latino
☐Female	☐Black	☐Amer. Indian/Alaskan Native	☐Unknown	☐Non-Hispanic
☐Transgender M to F	☐Hispanic	☐Native Hawaiian		☐Unknown
☐Transgender F to M		☐Other (specify):		

11. Telephone Numbers

Home: ( ) ________ Work: ( ) ________

Cell: ( ) ________ Pager: ( ) ________

12. Domestic Status

☐Single ☐Civil Union ☐Separated
☐Married ☐Divorced ☐Widowed

13. Has your domestic status changed in the last year?

☐No ☐Yes: ____ / ____ / ____
(Month / Day / Year)

14. How many people live in your household? ______

Name ________ Relationship to Self ________
Name ________ Relationship to Self ________
Name ________ Relationship to Self ________
Name ________ Relationship to Self ________
Name ________ Relationship to Self ________
Name ________ Relationship to Self ________

List any additional people who reside with you but are not related to you.

Name ________ Name ________

SECTION II- INFORMATION ON INSURED

15. Your relationship to the insured if insured is other than yourself.	16. Name of Insured	Social Security Number - -
☐Self ☐Spouse/Partner	Street Address	Telephone Number ( ) -
☐Child ☐Other: ______	City, State, Zip Code	County

SECTION III- HOUSEHOLD INCOME AND ASSETS

17. Enter your MONTHLY income. If your income from any source is "0", enter "0" in that space. DO NOT LEAVE ANY BLANKS! You MUST provide verification of all sources of income (2 current pay stubs, SSI, SSD, Pension, Disability benefit stubs,

$ ______________ Salary/Wages (before payroll deductions)
$ ______________ Unemployment Benefits
$ ______________ Pension or Private Disability
$ ______________ Interest or Dividend Income
$ ______________ Alimony or Child Support
$ ______________ Rental Income (after expenses)
$ ______________ Other (Specify): ____________________
$ ______________ Total Household Income*

$ ______________ ☐ Supplemental Security Benefits
$ ______________ ☐ Social Security Income
$ ______________ ☐ Social Security Disability Benefits
$ ______________ ☐ Medicaid Benefits
$ ______________ ☐ Medicare Benefits

*If you are married/civil union, enter your income PLUS the income of your spouse/partner; if you are claimed as a dependent for income tax purposes, provide proof of income for the claimant.

18. Enter your cash assets. List total cash assets including the cash value of savings accounts, checking accounts, IRA's, CD's, money market accounts, stocks and bonds. You MUST provide verification of all assets (2 current statements for each savings and checking account and an-up-to-date statement of all other assets. **ASSETS ARE LIMITED TO $25,000.00.**

$ ______________ Savings Account
$ ______________ Checking Account
$ ______________ Stocks and/or Bonds
$ ______________ Other (Specify): ____________________
$ ______________ Total Cash Assets

$ ______________ Certificate of Deposit (CD)
$ ______________ Money Market Account
$ ______________ Additional Residence/Real Estate Property

19. Did you file a Federal, State or City Income Tax Return last year?

☐Yes* ☐No

20. Were you listed as a dependent on a family member's Federal, State, or City Income Tax Return last year?

☐Yes* ☐No

***If YES, you must submit copies of the signed returns, including any and all attached schedules with this application.**

SECTION IV - ADDITIONAL CONTACT PERSON

In the event that we need information regarding your participation in this program and you are unavailable, please indicate someone we may contact on your behalf who is aware of your condition (preferably someone NOT living with you).

21. Name of Contact		22. Relationship to Patient
23. Street Address, City, State, Zip Code		24. Home Phone Number
25. Work Telephone Number	26. Fax Number	27. Cell Phone Number

SECTION V - CASE MANAGER INFORMATION (IF HIS OR HER ASSISTANCE WAS PROVIDED IN COMPLETION OF APPLICATION)

28. Name of Case Manager		29. Agency Affiliation
30. Street Address, City, State, Zip Code		
31. Work Telephone Number	32. Fax Number	33. Cell Phone Number

SECTION VI - CERTIFICATION BY APPLICANT

a. I certify that the information given is true and accurate to the best of my knowledge and that I know that I can be prosecuted for perjury if I have intentionally provided false information.
b. I will notify the Program immediately if my/our income or assets rise above legal limits (as stated in the instructions); if I move from New Jersey; if I change my present residential address or telephone number; if there is any change in premium payments or policy type; or if there is a change in any other information pertinent to my participation in this program.
c. I understand that I may be visited by representatives of the New Jersey Department of Health, Health Insurance Continuation Program, in order to verify my/our eligibility.
d. I understand that the New Jersey Department of Health, Health Insurance Continuation Program is entitled to repayment for incorrectly provided benefits. I further understand that I will be held liable for any premium payments that are determined to have been incorrectly provided on my behalf.

34. Signature of Applicant		35. Date of Application
36. Signature of Spouse/Partner, if Married/Civil Union		37. Date
38. Name of Witness (Print)	39. Signature of Witness	40. Date