

**New Jersey Department of Health and Senior Services  
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 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

**Question 2 and 16** - Providing your Social Security Number is optional; however, it will speed up the processing of your application.

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 III - INCOME AND ASSETS**

Question 16 - 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:

<u>Number of Persons in Household</u>	<u>Maximum Allowable Household Income</u>
1	\$54,150
2	72,850
3	91,550
4	110,250
5 or more	128,950

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

Question 17 - 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.

<p style="text-align: center;"><b><u>BEFORE YOU MAIL YOUR APPLICATION:</u></b></p> <p style="text-align: center;"><b><u>REVIEW THIS CHECKLIST AND MAKE SURE THAT EACH OF THE FOLLOWING ITEMS IS MAILED WITH YOUR APPLICATION:</u></b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (DHAS-31) (Completed and signed)</li><li><input type="checkbox"/> TWO (2) PROOFS OF RESIDENCY</li><li><input type="checkbox"/> VERIFICATION OF INCOME (pay stubs)</li><li><input type="checkbox"/> INCOME TAX RETURN (most recent)</li><li><input type="checkbox"/> VERIFICATION OF ASSETS (bank statements)</li><li><input type="checkbox"/> HEALTH INSURANCE INFORMATION FORM (DHAS-39) (Completed and signed)</li><li><input type="checkbox"/> ORIGINAL PREMIUM NOTICE WITH PREMIUM INFORMATION</li><li><input type="checkbox"/> PHYSICIAN CERTIFICATION (DHAS-40) (Completed and signed)</li><li><input type="checkbox"/> AUTHORIZATION/RELEASE OF INFORMATION (DHAS-41) (Completed and signed)</li><li><input type="checkbox"/> CONFIDENTIALITY RELEASE (DHAS-42) (Completed and signed)</li><li><input type="checkbox"/> DRIVER'S LICENSE (If licensed)</li><li><input type="checkbox"/> COPY OF INSURANCE CARD</li></ul>
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**MAIL ABOVE ITEMS (COMPLETED APPLICATION) TO:**

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES  
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.

<p><b>DO YOU CURRENTLY HAVE HEALTH INSURANCE COVERAGE?</b>    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p><b>IF "YES," PLEASE COMPLETE THIS APPLICATION.</b></p> <p><b>IF "NO," DO NOT CONTINUE SINCE YOU ARE <u>NOT</u> ELIGIBLE FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM.</b></p>
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**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? <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;"><b>NOTE: TWO (2) PROOFS OF RESIDENCY MUST ACCOMPANY YOUR APPLICATION.</b></p>													
8. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M	9. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Multiple Races <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian/Alaskan Native <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other (specify): _____												
11. Telephone Numbers Home: (    ) _____    Work: (    ) _____ Cell: (    ) _____    Pager: (    ) _____													
12. Domestic Status <input type="checkbox"/> Single <input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	13. Has your domestic status changed in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ / _____ / _____ (Month / Day / Year)												
14. How many people live in your household? _____ <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Name _____</td> <td style="width: 50%; border: none;">Relationship to Self _____</td> </tr> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Relationship to Self _____</td> </tr> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Relationship to Self _____</td> </tr> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Relationship to Self _____</td> </tr> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Relationship to Self _____</td> </tr> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Relationship to Self _____</td> </tr> </table> List any additional people who reside with you but are not related to you. Name _____    Name _____		Name _____	Relationship to Self _____	Name _____	Relationship to Self _____	Name _____	Relationship to Self _____	Name _____	Relationship to Self _____	Name _____	Relationship to Self _____	Name _____	Relationship to Self _____
Name _____	Relationship to Self _____												
Name _____	Relationship to Self _____												
Name _____	Relationship to Self _____												
Name _____	Relationship to Self _____												
Name _____	Relationship to Self _____												
Name _____	Relationship to Self _____												

**SECTION II - INFORMATION ON INSURED**

15. Your relationship to the insured if insured is other than yourself. <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	16. Name of Insured _____	Social Security Number _____ - _____
	Street Address _____	Telephone Number (    ) _____ - _____
	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)	\$ _____	<input type="checkbox"/> Supplemental Security Benefits
\$ _____	Unemployment Benefits	\$ _____	<input type="checkbox"/> Social Security Income
\$ _____	Pension or Private Disability	\$ _____	<input type="checkbox"/> Social Security Disability Benefits
\$ _____	Interest or Dividend Income	\$ _____	<input type="checkbox"/> Medicaid Benefits
\$ _____	Alimony or Child Support	\$ _____	<input type="checkbox"/> Medicare Benefits
\$ _____	Rental Income (after expenses)		
\$ _____	Other (Specify): _____		
\$ _____	Total Household Income*		

\*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	\$ _____	Certificate of Deposit (CD's)
\$ _____	Checking Account	\$ _____	Money Market Accounts
\$ _____	Stocks and/or Bonds	\$ _____	Additional Residence/Real Estate Property
\$ _____	Other (Specify): _____		
\$ _____	Total Cash Assets		

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 and Senior Services, Health Insurance Continuation Program, in order to verify my/our eligibility.
- d. I understand that the New Jersey Department of Health and Senior Services, 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