NJ FamilyCare
Aged, Blind, Disabled Programs

SECTION 1 Applicant

Applicant’s Name: ________________________________________________

Home Address: ___________________________________________________

Current Mailing Address (if different from above):

Applicant’s Phone Number: ___________________________ E-mail Address: ________________________________

Is the Applicant Blind or Disabled: ☐ Yes  If yes, as of what date: _____________________ ☐ No

Applicant in need of Long Term Services and Supports (see Brochure) ☐ Yes ☐ No

Have you ever applied for Long Term Services and Supports before?

☐ Yes  If yes, which county _____________________________ ☐ No

Has the applicant applied for Supplemental Security Income (SSI)?

☐ Yes  If yes, when ___ ___ – ___ ___ ___ ___ ☐ No

SECTION 2 Demographic Information for the Applicant

Date of Birth: ____ ____ – ____ ____ – ____ ____ ____  Sex: ☐ Male ☐ Female

Citizenship Status:

☐ US Citizen ☐ Refugee ☐ Asylee ☐ Legal Alien __________________ Date of Entry

Place of Birth: City ______________________________  State _________________ Country__________________

Social Security Medicare

Number: ___________ – ___________ – ___________ ID Number: _____________________________

Marital Status: ☐ Single ☐ Married, Date _________________ ☐ Divorced, Date _________________

☐ Widowed ☐ Separated, Date _________________ ☐ Child (under age 19)
SECTION 3  Spouse’s Name

Also include if divorced, separated or widowed in the past 5 years.

Spouse’s Name: ________________________________  ____________________  _____________  ______________________

Spouse’s Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___

Month  Day  Year

Spouse’s Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Is this person also applying for the Aged, Blind, Disabled Programs?

☑ No  ☐ Yes, please complete the Spouse Information form.

SECTION 4  Assistance with Application

The applicant can choose someone to help them complete their application. We can contact this person for more information. Select Below:

☐ Authorized Representative
  - Complete the Designation of Authorized Representative Form (included).

☐ Power of Attorney

☐ Legal Guardian

☐ Attorney

☐ Spouse

☐ Other, please identify relationship ______________________________________________________

Provide the following information for this person:

Name __________________________________________________________________________________________

Address ____________________________________________  _______________________  ______   _____________

Street  City             State  Zip Code

Phone Number: (___ ___) ___ ___ - ___ ___ ___ ___  E-mail Address: _____________________________________
**SECTION 5 Health Insurance Information**

- **Medicare Part A**  
  Date Eligible ________________
  Does the Applicant pay a premium?  
  ☑ Yes  How Much? ________________  
  ☐ No

- **Medicare Part B**  
  Date Eligible ________________
  Does the Applicant pay a premium?  
  ☑ Yes  How Much? ________________  
  ☐ No

- **Medicare Part C**  
  Date Eligible ________________
  Does the Applicant pay a premium?  
  ☑ Yes  How Much? ________________  
  ☐ No

- **Medicare Part D**  
  Date Eligible ________________
  Does the Applicant pay a premium?  
  ☑ Yes  How Much? ________________  
  ☐ No

Does the Applicant have any other health insurance coverage?  
☐ Yes  ☐ No

If yes, list below the name of the health coverage, policy number, and any premium costs

<table>
<thead>
<tr>
<th>Name of Policy</th>
<th>Policy Number</th>
<th>Policy Premium</th>
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Does the Applicant have Long Term Care Insurance?  
☐ Yes  ☐ No

Does the Applicant have a New Jersey Department of Banking and Insurance approved Long Term Care Partnership Policy?  
☐ Yes  ☐ No

If the Applicant answered yes to either of these questions, please provide a copy of the policy(s).
SECTION 6  Living Arrangements

Applicant’s current living arrangement, check all that apply.

- [ ] Home: Own
- [ ] Rent
- [ ] Living with Spouse
- [ ] Nursing Facility
- [ ] Assisted Living Facility
- [ ] Residential Care Facility
- [ ] Renting a room(s) in another person’s residence
- [ ] Living with Relative or Friend
- [ ] Other: Living Arrangement: _______________________________________

List other people living with the Applicant; include name, age and relationship
________________________________________________________________________
________________________________________________________________________

SECTION 7  Income Information

This section talks about the income that the Applicant receives. Income is any cash or in kind support that can be used for food or shelter.

Income can be wages, tips, and commissions. Income can also be government benefits (such as Social Security Benefit), interest or dividends.

- [ ] I do not have any income. If not, how do you pay your bills? ________________________

Current Job & Income Information

Does the Applicant have any income from employment?

- [ ] Employed
  If Applicant is currently employed, tell us about Applicant’s income.
  Start with question 1.

- [ ] Self-employed
  Skip to question 10.

- [ ] Not employed
  Skip to question 11.

CURRENT JOB 1:

1. Employer name and address __________________________________________________________
   ____________________________________________________________

2. Employer phone number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

3. Wages/tips (before taxes)  [ ] Hourly  [ ] Weekly  [ ] Every 2 weeks
   [ ] Twice a month  [ ] Monthly  [ ] Yearly $_____________________

4. Average hours worked each WEEK __________________________

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Date Applied __________________________
Registration # __________________________
CURRENT JOB 2:
(If the Applicant has more jobs and needs more space, attach another sheet of paper.)

5. Employer name and address ____________________________________________________________

6. Employer phone number (___ ___ ___) ___ ___ ___-___ ___ ___ ___

7. Wages/tips (before taxes)  ☐ Hourly  ☐ Weekly  ☐ Every 2 weeks
   ☐ Twice a month  ☐ Monthly  ☐ Yearly $__________________________

8. Average hours worked each WEEK ____________________________

9. In the past year, did the Applicant:  ☐ Change jobs  ☐ Stop working
   ☐ Start working fewer hours  ☐ None of these

10. If self-employed, answer the following questions:
    a. Type of work _________________________________________________________________
    b. How much net income (profits once business expenses are paid) will the Applicant
       get from this self-employment this month? $__________________________

11. OTHER INCOME THIS MONTH:
    Check all that apply, and give the amount and how often does the Applicant get it.
    ☐ None
    ☐ Unemployment $__________________________ How often?_________________________
    ☐ Pensions $__________________________ How often?_________________________
    ☐ Social Security $__________________________ How often?_______________________
    ☐ Retirement accounts $__________________________ How often?________________
    ☐ Alimony received $__________________________ How often?_____________________
    ☐ Child Support $__________________________ How often?_______________________
    ☐ Work Compensation/Disability $__________________________ How often?________
    ☐ Inheritance $__________________________ How often?_______________________
    ☐ Net rental/royalty $__________________________ How often?___________________
    ☐ Annuity $__________________________ How often?___________________________
    ☐ Other income $__________________________ How often?_______________________

12. YEARLY INCOME: Complete only if your income changes from month to month.
If you don’t expect changes to your monthly income, skip to the next page.

   Your total income this year $__________________________
   Your total income next year (if you think it will be different) $__________________________

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Date Applied ____________________________
Registration # ____________________________
SECTION 7a  Spouse’s Income

Please complete the following section with all information on Spouse's income

Current Job & Income Information

- **Employed**
  - If Spouse is currently employed, tell us about Spouse's income. Start with question 13.

- **Self-employed**
  - Skip to question 22.

- **Not employed**
  - Skip to question 23.

**CURRENT JOB 1:**

13. Employer name and address

14. Employer phone number (___  ___  ___) ___  ___  ___ - ___  ___  ___  ___

15. Wages/tips (before taxes)
   - Hourly
   - Weekly
   - Every 2 weeks
   - Twice a month
   - Monthly
   - Yearly
   - $ __________________

16. Average hours worked each WEEK _________________________________

**CURRENT JOB 2:**

(If the Spouse has more jobs and need more space, attach another sheet of paper.)

17. Employer name and address

18. Employer phone number (___  ___  ___) ___  ___  ___ - ___  ___  ___  ___

19. Wages/tips (before taxes)
   - Hourly
   - Weekly
   - Every 2 weeks
   - Twice a month
   - Monthly
   - Yearly
   - $ __________________

20. Average hours worked each WEEK _________________________________

21. **In the past year, did the Spouse:**
   - Change jobs
   - Stop working
   - Start working fewer hours
   - None of these

22. **If Spouse is self-employed, answer the following questions:**
   
a. Type of work ________________________________

   b. How much net income (profits once business expenses are paid) will the Spouse get from this self-employment this month? $ __________________

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Date Applied __________________
Registration # __________________
23. **OTHER INCOME THIS MONTH:**
Check all that apply, and give the amount and how often does the Spouse get it.
- [ ] None
- [ ] Unemployment $____________ How often? __________________________
- [ ] Pensions $____________ How often? __________________________
- [ ] Social Security $____________ How often? __________________________
- [ ] Retirement accounts $____________ How often? __________________________
- [ ] Alimony received $____________ How often? __________________________
- [ ] Child Support $____________ How often? __________________________
- [ ] Work Compensation/Disability $____________ How often? __________________________
- [ ] Inheritance $____________ How often? __________________________
- [ ] Net rental/royalty $____________ How often? __________________________
- [ ] Annuity $____________ How often? __________________________
- [ ] Other income $____________ How often? __________________________

24. **YEARLY INCOME:**
Complete only if your income changes from month to month.
If you don't expect changes to your Spouse's income, skip to the next page.

- Spouse's total income **this year** $ ________________
- Spouse's total income **next year** (if you think it will be different) $ ________________
Resources for Applicant and Applicant’s Spouse

Please detail all resources owned in full or in part by the Applicant, and/or the Applicant’s Spouse.

- □ Cash on hand $____________________

**ACCOUNTS:** This includes but is not limited to, checking, savings, business checking accounts, ABLE Accounts, Certificates of Deposit (CD), Holiday/Vacation club accounts, Credit Union accounts, Burial Accounts/Funeral Trusts owned or closed by the Applicant and/or Applicant’s Spouse within 60 months of application date.

<table>
<thead>
<tr>
<th>Account Name</th>
<th>Bank Address</th>
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</thead>
<tbody>
<tr>
<td>Name(s) on Account</td>
<td></td>
</tr>
<tr>
<td>Account or Certificate #</td>
<td>Current Value</td>
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<tr>
<td>If Closed, Date Closed &amp; Value</td>
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</table>

**FOR OFFICE USE ONLY**

Date Applied ______________________________________________________
Registration # ______________________________________________________
INVESTMENTS: Including but not limited to: Individual Retirement Accounts (IRAs), Keogh Accounts (401K), Retirement Plans (403B), Land/Mineral Rights, Business Equipment and Inventory, Promissory Notes and Contracts, Stocks, Bonds owned or traded/closed by the Applicant and/or Applicant’s Spouse within 60 months of application date.

**No Investments**

<table>
<thead>
<tr>
<th>Type of Investment</th>
<th>Company</th>
<th>Account #</th>
<th>Current Value</th>
<th>If Closed, Date Closed &amp; Value</th>
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PROPERTY: Properties owned solely by the Applicant, with the Applicant’s Spouse and/or with others (including but not limited to Other Homes, Land, Buildings, Time Shares, Life Estates or sold within the last 60 months).

**No Property**

<table>
<thead>
<tr>
<th>Type of Real Estate</th>
<th>Address</th>
<th>Liens, Mortgages or Incumbrances</th>
<th>Fair Market Value</th>
<th>Owners</th>
<th>If Sold, Date</th>
</tr>
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Date Applied __________________________
Registration # _______________________
**LIFE INSURANCE POLICIES**
List all life insurance policies owned by the Applicant and/or Applicant’s Spouse or for which the Applicant(s) are named insured

No Life Insurance

<table>
<thead>
<tr>
<th>Owner</th>
<th>Insured</th>
<th>Insurance Company</th>
<th>Policy #</th>
<th>Face Value</th>
<th>Cash Value</th>
<th>Term or Whole Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Insured</td>
<td>Insurance Company</td>
<td>Policy #</td>
<td>Face Value</td>
<td>Cash Value</td>
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<td>Policy #</td>
<td>Face Value</td>
<td>Cash Value</td>
<td>Term or Whole Life</td>
</tr>
</tbody>
</table>

Does the Applicant have any knowledge of being named a beneficiary on someone else’s policy? ☐ Yes ☐ No

**VEHICLES:** List all vehicles owned by the Applicant and/or Applicant’s Spouse, applying for benefits. List all types of vehicles, including but not limited to, cars, vans, trucks, motor homes, motorcycles, boats, etc.

No Vehicles

<table>
<thead>
<tr>
<th>Owner</th>
<th>Year/Make</th>
<th>Model/Style</th>
<th>Primary Use</th>
<th>Amount Owed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Year/Make</td>
<td>Model/Style</td>
<td>Primary Use</td>
<td>Amount Owed</td>
</tr>
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FOR OFFICE USE ONLY

Date Applied ________________________________
Registration # ________________________________

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TRUSTS
Testamentary Trust ☐ Special Needs Trust ☐ Qualified Income Trust ☐
Grantor ________________________________________________________________
Trustee ________________________________________________________________
Beneficiary ______________________________________________________________

Trust was funded by ☐ Applicant ☐ Inheritance ☐ Will ☐ Lawsuit ☐ Other
Tax ID# ________________________________ Date trust was initially funded ________________

Burial Arrangements
Does the Applicant own any prepaid burial contracts that are irrevocable or revocable?
  ☐ Yes  If yes, please send contract.  ☐ No
  ☐ Burial plots
  ☐ Account set aside for burial  Account #______________________________ Value ________________
Identified Funeral Home (name and address) _____________________________________________________

Has the Applicant or anyone else set up a burial arrangement or contract through a life insurance policy?
  ☐ Yes  If yes, please send policy  ☐ No

OTHER RESOURCES NOT LISTED
_________________________________________________________________________________________

Has the Applicant established a Plan of Liquidation for any of the resources in Section 7?
  ☐ Yes  ☐ No

SECTION 9 Transfers
Did the Applicant and/or Applicant’s Spouse trade, give away, or sell resources in which the Applicant and/or Applicant’s Spouse had an interest within the last 60 months, including but not limited to cash, real estate, vehicles, businesses, stocks, bank account?
  ☐ Yes  If yes, complete the information below for each transfer  ☐ No

<table>
<thead>
<tr>
<th>Item Transferred</th>
<th>Transfer Date</th>
<th>Market Value</th>
<th>Amount Received</th>
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FOR OFFICE USE ONLY

Date Applied ____________________________________________
Registration # ________________________________
SECTION 10  Legal Issues

Are there any pending claims such as lawsuits, divorce settlements, inheritance, accident claims, Medical Malpractice or other claims?  ☐ Yes  ☐ No

If Yes, provide details of the claims including but not limited to date monies were received and type of claim.

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Attorney’s Name __________________________________________

Attorney’s Phone Number (___ ___ ___) ___ ___ ___- ___ ___ ___

Attorney’s Address _______________________________________

Will the Applicant and/or Applicant’s Spouse file a lawsuit in the future?  ☐ Yes  ☐ No

Does anyone owe the Applicant and/or the Applicant’s Spouse money, for example loans, promissory notes and/or mortgages?  ☐ Yes  ☐ No

If yes, provide details regarding these arrangements _____________________________________________

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Has the Applicant received medical services within the past 3 months?  ☐ Yes  ☐ No

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Date Applied __________________________________________

Registration # _________________________________________
SECTION 11 Select the Applicant’s Health Plan

Choose a Health Plan from the list below. If the Applicant does not choose now, the Applicant will have an opportunity to select a Health Plan before enrollment occurs. The Applicant must be enrolled in a Health Plan to receive all of the services offered through NJ FamilyCare. The Health Plan selected only applies if the Applicant(s) is eligible for NJ FamilyCare. If the Applicant(s) needs assistance selecting the Applicant(s) Health Plan, contact a Health Benefits Coordinator at 1-800-701-0710, TTY 1-800-701-0720.

Choose One:

- Aetna Better Health® of New Jersey (Available in ALL counties)
- Amerigroup New Jersey, Inc. (Available in ALL counties; except Salem county)
- Horizon NJ Health (Available in ALL counties)
- UnitedHealthcare Community Plan (Available in ALL counties)
- WellCare Health Plans of New Jersey (Available in ALL counties, except Burlington, Cape May, Hunterdon and Ocean counties)

I understand that if I’m found eligible and because I have joined a Health Plan, I must follow the rules for obtaining health care from the Health Plan. I understand that I must let my Health Plan and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my Health Plan. I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist. I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the Health Plan as soon as possible after I, or the family member, go to the hospital. I understand that I must keep any medical appointment I have scheduled with a doctor and, if I cannot, I must call the doctor’s office to cancel the appointment. I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the Health Plan, I may have to pay for that doctor’s services because NJ FamilyCare will not pay for the unapproved service or visit. I understand that I may change to another Health Plan and that I can call the Health Benefits Coordinator to help me do that. I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the Health Plan and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the Health Plan.
SECTION 12 Rights and Responsibilities

Before signing this document, please read the rights and responsibilities outlined below. If there is anything you do not understand or have questions about, please ask for clarification.

• The information I gave on this form is true to the best of my knowledge. I realize that if I knowingly give false information OR if I knowingly withhold information and I get health benefits for which I am not eligible, I can be criminally punished for fraud and I may have to pay Medicaid for any medical bills which are paid incorrectly.

• If I am a third party applying on behalf of another person, as evidenced by a completed Designation of Authorized Representative form, my signature below indicates that this application has been examined by or read to the applicant and, to the best of my knowledge, the facts are true and complete. I understand as a third party I may be criminally punished for knowingly providing false information.

• I understand that any information I give is subject to verification by the NJ Department of Human Services (DHS). I understand that my medical benefits may be reduced, denied, or stopped because of information received.

• I hereby give permission to DHS to contact any individual or other source who may have knowledge about my circumstances or the circumstances of a person necessary for this application (including, but not limited to, IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, financial institutions and/or credit reporting services), for the sole purpose of verifying the statements I have made.

Estate Recovery

• I understand that Medicaid payments for services received on or after age 55 may be reimbursable to the State of New Jersey from the estate of an individual who received Medicaid benefits. I also understand that this reimbursement may include, but not be limited to, capitation payments made to a managed care organization (MCO) or transportation broker for health coverage, regardless of whether the beneficiary receives services from an individual provider or entity that is reimbursed by the MCO or transportation broker. For more information about Estate Recovery, visit [insert link]

• I agree to tell the Eligibility Determining Agency immediately of the following changes:
  1) If anyone receiving health benefits moves out of state;
  2) Changes in where we live or get our mail;
  3) Changes in other health insurance coverage;
  4) Changes in income and/or resources;
  5) Improvement in medical condition, if disabled;
  6) Marriages and/or divorces;

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Registration # ________________________________
7) Family members moving in or out of my household;  
8) Sale of my home or other property;  
9) Student status.

I understand that failure to do so may result in incorrectly paid benefits and I may have to 
reimburse the State of New Jersey for those benefits.

• I understand that the outcome of this application may be shared with any provider providing 
services or who provided services to the applicant/beneficiary.

• I understand, as a condition of eligibility for medical assistance, that I have assigned to the 
Commissioner of Human Services, any rights to support for the purpose of medical care as 
determined by a court or administrative order and any rights to payment for medical care from 
any third party.

• I understand that I may request a fair hearing if I am not satisfied with any action taken 
regarding my application.

• I may be eligible for retroactive NJ FamilyCare coverage for unpaid covered medical services by 
Medicaid Fee For Service providers during the three (3) months prior to this application. 
I further understand that these retroactive benefits will only apply to the month(s) that 
eligibility requirements are met.

• I understand that an individual is only permitted to retain $2,000 or $4,000 in applicable 
program resources in order to be eligible. I understand that if I am seeking Long Term Services 
and Supports, NJ FamilyCare will examine transfers of resources that occurred within the look 
back period before, and anytime after, my first date of applying for benefits.

• I give third parties permission to share information about me with authorized State and County 
staff conducting investigations pertaining to fraud, fraud prevention and misrepresentation. 
Third parties include, but are not limited to, financial institutions, credit reporting agencies, 
landlords, public housing agencies, schools, utility companies, insurance agencies, employers, 
other governmental agencies and others as they apply. I further authorize taxing authorities to 
release copies of my income tax returns. I also understand that my permission for release is 
effective for six (6) months after my benefits stop.

• I understand that by accepting NJ FamilyCare, I give the NJ Department of Human Services the 
right to any medical support or payments from third parties who would be legally responsible 
for any medical services paid by NJ FamilyCare for me or any member of my household. I agree 
to release any medical information needed by the NJ FamilyCare Program or others for the 
purpose of paying or receiving payment of medical bills. I understand that this is required to 
get coverage. I agree to help in obtaining medical support and payments from anyone who is 
legally responsible.
NOTE: The submission of a Social Security number (SSN) is mandatory in accordance with 42 U.S.C. 1320b-7.

The SSNs provided (including for a husband or wife, family members, or dependents) will be used to associate records pertaining to applicants and other persons necessary for the determination of eligibility, to verify identity, to verify income, to check other financial records such as bank account information, to the extent it is useful in verifying eligibility or the amount of medical assistance payments under 42 CFR 435.940 through 435.960, and preventing duplicate participation or incorrectly paid benefits for you and for persons in your household. The SSNs will be used in computer matching and program reviews or audits. These procedures are designed to determine eligibility and to identify persons who fraudulently or wrongfully participate in Medicaid and DMAHS programs. Such persons may be subjected to criminal action, administrative claims, and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

SECTION 13 Signature

I, by signing below, attest that I have read and agree to these statements, and that they are truthful and accurate. I fully realize that the Eligibility Determining Agency and NJ Department of Human Services rely upon the truth and accuracy of my statements.

Applicant's Signature __________________________ Date (mm/dd/yyyy) ______________

Authorized Representative Name __________________________ Relationship __________________________

Authorized Representative Signature __________________________ Date (mm/dd/yyyy) ______________

This application can not be considered until it is received by the Eligibility Determining Agency.
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