

NJ FamilyCare Aged, Blind, Disabled Programs

APPLICATION

SECTION 1 Applicant

Applicant's Name: _____
Last First Middle Maiden Name

Home Address: _____
Street City State Zip Code

Current Mailing Address (if different from above):

_____ Street City State Zip Code

If Applicant has not lived at the Home Address for 5 years, tell us the previous address:
(Attach additional information if needed)

_____ Street City State Zip Code

Applicant's Phone Number: (____) _____ - _____ Applicant's 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 _____ - _____ Year _____ No

SECTION 2 Demographic Information for the Applicant

Date of Birth: _____ - _____ - _____ Sex: Male Female
Month Day Year

Citizenship Status: US Citizen Refugee Asylee Legal Alien _____
 Not Lawfully Admitted Date of Entry

Place of Birth: City _____ State _____ Country _____

Social Security Number: _____ - _____ - _____ Medicare ID Number: _____

Marital Status: Single Married, Date _____ Divorced, Date _____
 Widowed Separated, Date _____ Child (under age 19)

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HMO choice	_____
Date Applied	_____
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SECTION 3 Spouse's Name

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

Spouse's Name: _____
Last
First
Middle
Maiden 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: _____

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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

Name of Policy	Policy Number	Policy Premium

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).

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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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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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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) \$ _____

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SECTION 8 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.

<p>Account Name _____</p> <p>Bank Address _____</p> <p>Name(s) on Account _____</p> <p>Account or Certificate # _____ Current Value _____</p> <p>If Closed, Date Closed & Value _____</p>
<p>Account Name _____</p> <p>Bank Address _____</p> <p>Name(s) on Account _____</p> <p>Account or Certificate # _____ Current Value _____</p> <p>If Closed, Date Closed & Value _____</p>
<p>Account Name _____</p> <p>Bank Address _____</p> <p>Name(s) on Account _____</p> <p>Account or Certificate # _____ Current Value _____</p> <p>If Closed, Date Closed & Value _____</p>
<p>Account Name _____</p> <p>Bank Address _____</p> <p>Name(s) on Account _____</p> <p>Account or Certificate # _____ Current Value _____</p> <p>If Closed, Date Closed & Value _____</p>

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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

Type of Investment _____
 Company _____
 Account # _____ Current Value _____
 If Closed, Date Closed & Value _____

Type of Investment _____
 Company _____
 Account # _____ Current Value _____
 If Closed, Date Closed & Value _____

Type of Investment _____
 Company _____
 Account # _____ Current Value _____
 If Closed, Date Closed & Value _____

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

Type of Real Estate _____
 Address _____
 Liens, Mortgages or Incumbrances _____ Fair Market Value _____
 Owners _____ If Sold, Date _____

Type of Real Estate _____
 Address _____
 Liens, Mortgages or Incumbrances _____ Fair Market Value _____
 Owners _____ If Sold, Date _____

Type of Real Estate _____
 Address _____
 Liens, Mortgages or Incumbrances _____ Fair Market Value _____
 Owners _____ If Sold, Date _____

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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

Owner _____
 Insured _____
 Insurance Company _____
 Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Owner _____
 Insured _____
 Insurance Company _____
 Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

Owner _____
 Insured _____
 Insurance Company _____
 Policy # _____ Face Value _____ Cash Value _____ Term or Whole Life _____

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

Owner _____
 Year/Make _____ Model/Style _____
 Primary Use _____ Amount Owed _____

Owner _____
 Year/Make _____ Model/Style _____
 Primary Use _____ Amount Owed _____

Owner _____
 Year/Make _____ Model/Style _____
 Primary Use _____ Amount Owed _____

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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

Item Transferred _____ Transfer Date _____
Market Value _____ Amount Received _____

Item Transferred _____ Transfer Date _____
Market Value _____ Amount Received _____

Item Transferred _____ Transfer Date _____
Market Value _____ Amount Received _____

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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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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.

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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 http://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf
- 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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- 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.

 **SIGN ON BACK** 

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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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**PRINT, SIGN and SEND to your
LOCAL COUNTY WELFARE AGENCY
at the appropriate address listed below.**

NEW JERSEY COUNTY WELFARE AGENCIES

<p>ATLANTIC COUNTY DIVISION OF INTERGENERATIONAL SERVICES - ABD MEDICAID 101 SOUTH SHORE RD NORTHFIELD, NJ 08225 609-645-7700</p>	<p>MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES 181 HOW LANE, P.O. BOX 509 NEW BRUNSWICK, NJ 08903 732-745-3500</p>
<p>BERGEN COUNTY BOARD OF SOCIAL SERVICES 218 ROUTE 17 NORTH ROCHELLE PARK, NJ 07662-3300 201-368-4200</p>	<p>MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES 3000 KOZLOSKI RD., P.O. BOX 3000 FREEHOLD, NJ 07728 732-431-6000</p>
<p>BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD. MOUNT HOLLY, NJ 08060-3335 609-261-1000</p>	<p>MORRIS COUNTY OFFICE OF TEMPORARY ASSISTANCE 340 W. HANOVER, P.O. BOX 900 MORRISTOWN, NJ 07963-0900 973-326-7800</p>
<p>CAMDEN COUNTY BOARD OF SOCIAL SERVICES ALETHA R. WRIGHT ADMINISTRATION BLDG. 600 MARKET ST. CAMDEN, NJ 08102-1255 856-225-8800</p>	<p>OCEAN COUNTY BOARD OF SOCIAL SERVICES 1027 HOOPER AVE., P.O. BOX 547 TOMS RIVER, NJ 08754-0547 732-349-1500</p>
<p>CAPE MAY COUNTY BOARD OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 4005 ROUTE 9 SOUTH RIO GRANDE, NJ 08242-1911 609-886-6200</p>	<p>PASSAIC COUNTY BOARD OF SOCIAL SERVICES 80 HAMILTON ST. PATERSON, NJ 07505-2057 973-881-0100</p>
<p>CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 275 NORTH DELSEA DR. VINELAND, NJ 08360-3607 856-691-4600</p>	<p>SALEM COUNTY BOARD OF SOCIAL SERVICES 147 S. VIRGINIA AVE. PENNS GROVE, NJ 08069-1797 856-299-7200</p>
<p>ESSEX COUNTY DEPARTMENT OF CITIZEN SERVICES DIVISION OF FAMILY ASSISTANCE & BENEFITS 18 RECTOR ST, 5TH FL. NEWARK, NJ 07102 973-733-3000</p>	<p>SOMERSET COUNTY BOARD OF SOCIAL SERVICES 73 E. HIGH ST., P.O. BOX 936 SOMERVILLE, NJ 08876-0936 908-526-8800</p>
<p>GLOUCESTER COUNTY DIVISION OF SOCIAL SERVICES 400 HOLLYDELL DR. SEWELL, NJ 08080 856-582-9200</p>	<p>SUSSEX COUNTY DIVISION OF SOCIAL SERVICES 83 SPRING ST., STE. 203. P. O. BOX 218 NEWTON, NJ 07860 973-383-3600</p>
<p>HUDSON COUNTY DEPARTMENT OF FAMILY SERVICES DIVISION OF WELFARE 257 CORNELISON AVENUE JERSEY CITY, NJ 07306 201-420-3000</p>	<p>UNION COUNTY DIVISION OF SOCIAL SERVICES 342 WESTMINSTER AVE. ELIZABETH, NJ 07208-3290 908-965-2700</p>
<p>HUNTERDON COUNTY DEPT OF HUMAN SERVICES DIVISION OF SOCIAL SERVICES P.O. BOX 2900 FLEMINGTON, NJ 08822-2900 908-788-1300</p>	<p>WARREN COUNTY DIVISION OF TEMPORARY ASSISTANCE AND SOCIAL SERVICES 1 SHOTWELL DRIVE BELVIDERE, NJ 07823 908-475-6301</p>
<p>MERCER COUNTY BOARD OF SOCIAL SERVICES 200 WOOLVERTON ST., P.O. BOX 1450 TRENTON, NJ 08650-2099 609-989-4320</p>	