State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

MICHELE K. GUHL
Commissioner

MARGARET A. MURRAY
Director

MEDICAID COMMUNICATION NO. 00-18 **DATE:** September 25, 2000

TO: County Board of Social Services Directors

SUBJECT: NJ FamilyCare Conversion Packet

REFERENCE: Converting NJ KidCare Parents into NJ FamilyCare

This past July, Governor Whitman signed into law the NJ FamilyCare (NJFC) health care legislation. This new legislation will allow parents and caretakers of children earning up to 200% of the Federal Poverty Level (FPL) and single adults and married couples without dependent children earning up to 100% FPL to receive health insurance through one of the State's contracted Health Maintenance Organizations (HMO).

To expedite the enrollment of eligible parents/caretakers of the children presently enrolled in NJ KidCare Plan A, we will be mailing to them the conversion packet, which is attached to this Medicaid Communication. Each packet will contain a letter to parents/caretakers (English and Spanish) informing them about NJFC, a NJFC County Conversion Form, a NJFC HMO Conversion Form (health profile), a NJFC Factsheet (English & Spanish) and a postage paid return envelope.

Each county Director has provided the county address where the returned conversion information should be mailed for processing. The addresses of active (as of August 2000) NJ KidCare Plan A children will be sorted by county. Before they are mailed, each packet will have the county's personalized return address on the exterior envelope and also on the postage paid return envelope that will be inserted into the packets.

The letter to the parents/caretakers will inform them of the benefits of enrolling into NJ FamilyCare along with the instructions that they must complete the NJFC County Conversion Form and the NJFC HMO Conversion Form in order to be enrolled. If assistance is needed, they are instructed to call their County Board of Social Services (CBOSS) and to refer to the factsheet for the number.

The information provided by NJFC County Conversion Form will make it possible to add the parents/caretakers to the child's case record so that they can be enrolled in the same HMO as their child. The parents will be uniquely identified by the appropriate program status code. Instructions concerning coding will be provided under separate cover.

The NJFC HMO Conversion form is being used to collect medical background of enrolling parents/caregivers and should to be forwarded to the Health Benefits Coordinator (HBC) located in your county agency after the eligibility has been confirmed. However, failure to return an HMO Conversion Form should not prevent a parent/caregiver from being added to the case number of their child(ren).

Caretakers who were not part of the budget unit under NJ KidCare, but are now requesting coverage under NJFC, will have to provide information and proof of monthly income. The NJFC factsheet will provide maximum income requirements. All of the NJFC conversion information returned by caretakers who are at or above 150% FPL must be forwarded to Birch & Davis for further processing and premium collection.

Finally, if an applicant answered "Yes" to question #4, on page 3, of the County Conversion Form, "Do you or your children have access to health insurance through your current employer?", we are asking that you make a copy of pages 1 and 2, and send them to Dennis Doderer at Premium Assistance Program, PO Box 712, Trenton, NJ 08625. This information will be used in the future as an initial outreach for the Premium Assistance Program.

If you have any questions concerning this enrollment process, please contact the Office of NJ FamilyCare at 609-588-3526.

Sincerely,

Margaret A. Murray
Director

MAM:Cm
Attachment (CWAs)
c: Christine Grant, Commissioner
William Conroy, Deputy Commissioner
Department of Health and Senior Services

David Heins, Director
Division of Family Development

Charles Venti, Director
Division of Youth and Family Services

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Child's NJ KidCare Number_____
(Only one is necessary)

Dear Parents or Caretakers:

We are pleased to inform you that Governor Whitman recently signed legislation allowing parents and caretakers of NJ KidCare children the opportunity to obtain affordable health coverage. This new health care coverage called NJ FamilyCare will increase access to affordable health insurance for New Jerseyans and allow previously uninsured adults to live healthier lives and receive medical services before more serious health problems develop.

NJ FamilyCare will provide a comprehensive package of health care services to uninsured parents and adults through an HMO. If you are enrolled in NJ FamilyCare, you will be covered under the same HMO as your children who are enrolled in NJ KidCare. Among the services covered under NJ Family Care are doctor visits, hospitalization, lab and x-ray, prescription drugs, and eye care. If monthly income that you reported when applying for NJ KidCare has your child(ren) enrolled in Plan A, then you to will be eligible for NJ FamilyCare Plan A. You will not have a monthly premium or co-payments for services. Please complete all of the questions on this NJ FamilyCare Conversion Form and also those on the HMO Conversion Form enclosed in this packet. Return them both in the postage paid envelope enclosed. **Please remember to add your child's NJ KidCare number at the top of each page.**

Please note that caretakers who are not biological or adoptive parents of the children living in their household **must identify their monthly income** by submitting the most recent documentation (monthly pay stubs) of that income along with this application to determine eligibility for NJ FamilyCare.

If you have any questions about NJ FamilyCare or completing these forms, please contact your local County Board of Social Services (see enclosed NJ FamilyCare Fact Sheet for telephone numbers).

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Child's NJ KidCare Number_____
(Only one is necessary)

Cobertura de la salud a costos razonables. Atención de calidad No. de NJ KidCare del niño (Sólo es necesario indicar un número)

Estimados padres o tutores:

Nos complace informarles que hace poco la Gobernadora Whitman firmó una ley que permite que los padres y tutores de niños inscritos en NJ KidCare tengan la oportunidad de obtener cobertura de la salud a costos razonables. Esta nueva cobertura de la salud se llama NJ FamilyCare y aumentará la asequibilidad al seguro de salud a costos razonables para todos los residentes de New Jersey y permitirá que los adultos que antes no tenían seguro gocen de una vida más saludable y reciban servicios médicos antes de desarrollar problemas de salud serios.

NJ FamilyCare proporcionará un paquete completo de servicios de cuidado de la salud por medio de una HMO a los padres y adultos que no tienen seguro. Si usted se inscribe en NJ FamilyCare estará cubierto por la misma HMO que cubre a sus niños inscritos en NJ KidCare. Algunos de los servicios que NJ FamilyCare proporciona son las consultas médicas, hospitalizaciones, análisis de laboratorio y radiografías, medicamentos con receta y la atención de la vista. Si su niño está inscrito en el Plan A de NJ KidCare cuando reportó su ingreso mensual, usted también se le inscribirá en el Plan A de NJ FamilyCare. Usted no tendrá que pagar primas mensuales ni dar pagos complementarios por los servicios. Por favor conteste todas las preguntas en este formulario de conversión a NJ FamilyCare (NJ FamilyCare Conversion Form), así como las del formulario de conversión a una HMO (HMO Conversión Form) que se adjuntan a este paquete. Envíe ambos formularios de regreso en el sobre con porte pagado anexo. **Por favor, no olvide indicar el número de NJ KidCare de su niño en la parte superior de cada página.**

Por favor recuerde que para determinar la elegibilidad para NJ FamilyCare de los tutores que no son los padres biológicos o adoptivos de los niños que viven en sus hogares, éstos **deben indicar su ingreso mensual** y adjuntar a su solicitud los documentos más recientes (talones de sus cheques mensuales) de dichos ingresos.

Si usted tiene alguna pregunta con respecto a NJ FamilyCare, o al llenar estos formularios, por favor comuníquese con la Junta de servicios sociales del condado (vea la hoja de datos de NJ FamilyCare para obtener los números de teléfono).

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Child's NJ KidCare Number_____
(Only one is necessary)

Name of Parent / Caretaker_____

Residential Address _____ **Mailing Address**_____ **Home Phone Number**_____

_____ _____ **Work Number**_____

_____ _____ **Beeper/Fax Number**_____

Residential County_____ **Mail County**_____

INSTRUCTIONS: This form is to be completed by the parent / caretaker who is applying for NJ FamilyCare. All information requested must be completed in order to process your application Please print.

FOR CARETAKERS WHO ARE NOT BIOLOGICAL OR ADOPTIVE PARENTS OF THE CHILDREN LIVING IN YOUR HOUSEHOLD, PLEASE INCLUDE PROOF OF RECENT INCOME RECEIVED BY MEMBERS OF YOUR HOUSEHOLD.

Last Name	First Name	Relationship to Child	Is this Person Requesting NJ Family Care? Y/N	Is this Person a U.S. Citizen?* Y/N	Social Security Number	Date of Birth MM/DD/YY	Marital Status (See Codes Below)	Sex M/F	Race Codes (See Codes Below)

Marital Status Codes: M-Married, S-Single, W-Widowed, D-Divorced, P-Separated
Race Codes: B-Black, S-Hispanic, W-White, I-American Indian/Alaska Native, A-Asian Pacific Islander, O-Other
*** If you are not a U.S. citizen, please include proof of alien status including visas and both sides of your legal permanent resident cards if applicable.**

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Child's NJ KidCare Number_____
(Only one is necessary)

1. Do any of the adults applying for NJ FamilyCare have unpaid medical bills from the past 3 months?

☐ Yes ☐ No If you Answered "Yes" please provide their name(s)_____

2. Are you applying for NJ FamilyCare because of accident or injury that may result in a lawsuit, receipt of workers compensation, or an insurance claim?
☐ Yes ☐ No If you Answered "Yes" please provide their name(s)_____

3. Is anyone in your household pregnant? ☐ Yes ☐ No If you Answered "Yes" please provide their name(s)_____
Estimated Delivery Dates 1._____ 2._____ If it is a multiple birth, how many?_____

PLEASE INCLUDE A POSITIVE PREGNANCY TEST BY A LAB OR PHYSICIAN AS PROOF OF PREGNANCY

4. Do you or your children have access to health insurance through your current employer? ☐ Yes ☐ No

5. Do any of the adults applying for NJ FamilyCare have health insurance? ☐ Yes ☐ No

6. Has any of the adults applying for NJ FamilyCare lost insurance within the past 6 months? ☐ Yes ☐ No

If you answered "Yes" to Question #5, or #6 please complete the section below.
PLEASE INCLUDE A COPY OF THE FRONT PAGE OF THE HEALTH INSURANCE POLICY, BOTH SIDES OF THE INSURANCE IDENTIFICATION CARD, AND A COPY OF THE INSURANCE TERMINATION LETTER, IF APPLICABLE.

Name of Covered Adult	Name of Policyholder	Insurance Company	Policy Number or Medicaid ID Number	Group I.D. Number	Is this Person Currently Receiving Benefits? Y/N	Date of Termination	Reason For Termination

Child's NJ KidCare Number_____
(Only one is necessary)

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BEFORE YOU SIGN, READ THE STATEMENTS OF UNDERSTANDING BELOW. SIGNING BELOW MEANS YOU HAVE READ AND UNDERSTAND BOTH SIDES OF THE MANAGED CARE APPLICANT PROFILE AND THAT YOU GRANT PERMISSION FOR NJ FAMILYCARE TO GIVE ALL INFORMATION OBTAINED HERE TO YOUR HEALTH PLAN. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE CALL YOUR LOCAL COUNTY BOARD OF SOCIAL SERVICES (SEE ENCOLOSED NJ FAMILYCARE FACT SHEET FOR TELEPHONE NUMBERS).

STATEMENTS OF UNDERSTANDING

I (we) understand and agree to the following:

- I understand that this document constitutes my application for NJ FamilyCare. Any adults living in my household and those adults listed on this application will be evaluated for eligibility for the NJ FamilyCare Program.
- The information given herein is true and complete to the best of my knowledge. Misrepresentation, failure to disclose information, or causing others to withhold information may be subject to prosecution or loss of benefits.
- The information given is subject to verification and, by signing this document, authorization is given to contact any individual or source for relevant information, including, but not limited to, the IRS, Social Security Wage and Benefits files, State Wage and Unemployment files, and/or credit reporting services for the sole purpose of verifying statements given. Information given will be used only in connection with this application for assistance.
- The information provided concerning medical conditions and previous health insurance will be provided to and may be verified by your HMO.
- The person who completes this application will advise the agency immediately of any changes in household size, living conditions, financial circumstances and/or health care coverage. This includes notification of new household members so that they can be evaluated for coverage under this program.
- I (we) may be granted the right to dispute any action taken in relation with this application.
- Any rights to payment for medical care from any third party are hereby assigned to the Commissioner of Human Services as a condition of eligibility.

If you need help with translation of this letter, please call your local County Board of Social Services.
Si necesita la carta traducida en Espanol por favor llame su officina local de servicios sociales.

_____ _____
SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE **DATE**

_____ _____
(Applicants Signature or Printed Name if Signed by Authorized Representative) (Date)

This program does not discriminate against anyone because of race, age, color, religion, sex, national origin, marital status, disability, or political belief.

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Parents/Caretakers with Children

- **NJ FamilyCare** can help meet the health care needs of parents/caretakers* who live in New Jersey and do not have health insurance coverage.
- **NJ FamilyCare** will provide a comprehensive package of health care services through one of the health maintenance organizations (HMO) available in each county. Services include: doctor visits, hospitalization, lab and x-ray, prescription drugs, eye care and glasses, and more.
- **Who is eligible?** Uninsured parents/caretakers may be eligible. Eligibility for NJ FamilyCare is based on the number of people in the family and the family's total monthly income. The chart below shows the **maximum** monthly income a family may have to be eligible for NJ FamilyCare:

Family Size	2	3	4	5	6	7
Maximum Monthly Income for Eligibility Year 2000	$1,875	$2,359	$2,842	$3,325	$3,809	$4,292

- **Other insurance?** To be eligible for NJ FamilyCare, parents/caretakers will need to be uninsured for a period of 6 months or more. However, there are some exceptions to this rule and parents should contact the toll free number for additional information.
- **Premiums, co-payments?** For families with low monthly incomes, there are no monthly premiums or copayments. Families who are earning the highest monthly incomes will pay a monthly premium of $25 for one parent/caretaker and additional $10 for the second parent/caretaker, total $35, plus the $15 monthly premium for their child(ren), enrolled in NJ KidCare.
- **Premium Assistance Program**: If you have access to employer-sponsored health coverage for your children, you may be eligible for the Premium Assistance Program. This program can assist you by paying a portion of the monthly premium for coverage through your employer's health plan.

Call toll-free 1-800-701-0710 (TTY 1-800-701-0720) to receive more information. If you are not sure you are eligible, please call us. Multilingual operators are available.

** Legal immigrants who are lawfully admitted for permanent residence, including parents, their children, adults and married couples without children can apply for NJ FamilyCare, even if they have lived in this country less than five years.*

Adults and Married Couples without Children

- **NJ FamilyCare** can help meet the health care needs of single adults* or married couples without dependent children, who live in New Jersey and do not have health insurance.
- **NJ FamilyCare** will provide a comprehensive package of health care services through one of the health maintenance organizations (HMOs) available in each county. Services include: doctor visits, hospitalization, lab and x-ray, prescription drugs, eye care and glasses, and more.
- **Who is eligible?** Uninsured single adults or married couples without dependent children may be eligible. Eligibility is based on monthly income. For the Year 2000, any single adult whose monthly income is less than or equal to **$696** or a married couple whose monthly income is less than or equal to **$938** could be eligible.
- **Other insurance?** Most adults will be eligible for NJ FamilyCare only if they have been uninsured for a period of 6 months or more. However, there are some exceptions to this rule. You should contact the toll-free number for additional information.
- **Premiums, co-payments?** There are **no monthly premiums** or **co-payments.**

For more information, contact your County Board of Social Services at:

Atlantic: 609-348-3001	Middlesex: 732-745-3615
Bergen: 201-368-4200	Monmouth: 732-431-6227
Burlington: 609-261-1000	Morris: 973-326-7272
Camden: 856-225-8800	Ocean: 732-349-1500
Cape May: 609-886-6200	Passaic: 973-881-0100
Cumberland: 856-327-0114	Salem: 856-299-7200
Essex: 973-733-3000	Somerset: 908-526-8800
Gloucester: 856-582-9200	Sussex: 973-383-3600
Hudson: 201-420-3000	Union: 908-965-3734
Hunterdon: 908-788-1300	Warren: 908-475-6301
Mercer: 609-989-4491	

Or Call 1-800-701-0710 Multilingual Operators Available

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Padres / Tutores con hijos

- **NJ FamilyCare** puede ayudar a satisfacer las necesidades de cuidado de la salud de padres / tutores* que viven en New Jersey pero que no cuentan con la cobertura de un seguro de salud.
- **NJ FamilyCare** proporcionará un paquete completo de servicios de cuidado de la salud por medio de una de las organizaciones de mantenimiento de la salud (HMO) disponibles en cada condado. Los servicios incluyen: consultas médicas, hospitalizaciones, análisis de laboratorio y radiografías, medicamentos con receta, atención de la vista y lentes, y otros.
- **¿Quién es elegible?** Padres / tutores que no tienen seguro. La elegibilidad para NJ FamilyCare se basa en el número de integrantes de una familia y el ingreso total mensual de la misma. El cuadro a continuación muestra el ingreso familiar **máximo** que una familia puede tener y ser elegible para NJ FamilyCare:

No. de integrantes	2	3	4	5	6	7
Ingreso mensual máximo para ser elegible en el año 2000	$1,875	$2,359	$2,842	$3,325	$3,809	$4,292

- **¿Otro tipo de seguro?** Para ser elegibles para NJ FamilyCare, los padres / tutores no deben tener seguro por un periodo de 6 meses o más. Sin embargo, hay algunas excepciones a esta regla y los padres interesados deben llamar al número telefónico gratuito para obtener información adicional.
- **¿Primas, co-pagos?** Para las familias con ingresos mensuales bajos, no hay primas mensuales ni co-pagos. Las familias con ingresos más altos pagarán una prima de $25 por un adulto y $10 adicionales por el segundo adulto para un total de $35, mas una prima de $15 mensuales de su(s) hijo(s) inscrito(s) en NJ KidCare.
- **Programa de asistencia para pagar primas:** Si usted puede recibir cobertura de la salud para sus niños por medio de su empleador, usted podría ser elegible para el Programa de asistencia para pagar primas. Este programa le puede ayudar al pagar una porción de la prima mensual de la cobertura que recibe por medio del plan de salud de su empleador.

Llame al número telefónico gratuito 1-800-701-0710 (1-800-701-0720, TTY para personas con problemas de audición) para obtener más información. Si no está seguro de ser elegible, por favor llámenos. Tenemos operadores multilingües disponibles.

**** Los inmigrantes legales que han recibido la residencia permanente legal, incluyendo padres, sus hijos, adultos y parejas casadas sin hijos pueden presentar su solicitud a NJ FamilyCare, aún si han vivido en el país por menos de cinco años.***

Adultos y parejas casadas sin hijos

- **NJ FamilyCare** puede ayudar a satisfacer las necesidades de cuidado de la salud de adultos solteros* o parejas casadas sin hijos dependientes, que viven en New Jersey pero que no cuentan con la cobertura de un seguro de salud.
- **NJ FamilyCare** proporcionará un paquete completo de servicios de cuidado de la salud por medio de una de las organizaciones de mantenimiento de la salud (HMO) disponibles en cada condado. Los servicios incluyen: consultas médicas, hospitalizaciones, análisis de laboratorio y radiografías, medicamentos con receta, atención de la vista y lentes, y otros.
- **¿Quién es elegible?** Los adultos solteros o parejas casadas sin hijos dependientes que no tienen seguro. La elegibilidad se basa en el ingreso mensual. Para el año 2000, cualquier adulto soltero cuyo ingreso mensual es menos o igual a **$696** podría ser elegible, así como las parejas casadas cuyo ingreso mensual es menos o igual a **$938**.
- **¿Otro tipo de seguro?** La mayoría de los adultos serán elegibles para NJ FamilyCare sólo si no han tenido seguro por un periodo de 6 meses o más. Sin embargo, hay algunas excepciones a esta regla. Los interesados deben llamar al número telefónico gratuito para obtener información adicional.
- **¿Primas, co-pagos?** No hay primas mensuales ni co-pagos.

Para más información, contacte a la Junta de servicios sociales de su condado llamando al:

Atlantic: 609-348-3001	**Middlesex: 732-745-3615**
Bergen: 201-368-4200	**Monmouth: 732-431-6227**
Burlington: 609-261-1000	**Morris: 973-326-7272**
Camden: 856-225-8800	**Ocean: 732-349-1500**
Cape May: 609-886-6200	**Passaic: 973-881-0100**
Cumberland: 856-327-0114	**Salem: 856-299-7200**
Essex: 973-733-3000	**Somerset: 908-526-8800**
Gloucester: 856-582-9200	**Sussex: 973-383-3600**
Hudson: 201-420-3000	**Union: 908-965-3734**
Hunterdon: 908-788-1300	**Warren: 908-475-6301**
Mercer: 609-989-4491	

O llame al 1-800-701-0710 Tenemos operadores multilingües disponibles

County:

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HMO PLAN CONVERSION FORM

Expected Enrollment Date:

(For Internal Use Only)

NJ KidCare No.:_____ Language Spoken:_____

Head of Household:_____

Address:_____ City/State/ZIP:_____

Soc. Security No:_____

Household Phone No.:_____

Adults/Caretakers Information:

Last Name	First	Date of Birth	Sex	Social Security Account Number

Parents/Caretakers Managed Care Applicant Profile

Please complete as much information below as possible. This information will help your new HMO know about you and your spouse's health care needs.

Part A

1 List Your or Your Spouse's Current Personal Doctor

Family Member (including self)	Personal Doctor (First & Last Name)	City where Personal Doctor is located

2 List Any Specialists Who Also Treat You or Your Spouse

Family Member (including self)	Specialist Information	Specialty
	Name	
	Address	
	City, State, Zip	
	Telephone	
	Name	
	Address	
	City, State, Zip	
	Telephone	
	Name	
	Address	
	City, State, Zip	
	Telephone	

3 Current Medical Problems (check all that apply)

☐ Heart	☐ Urinary Problems	☐ Paralysis	☐ Digestion/Bowel
☐ High Blood Pressure	☐ Breathing Problems	☐ Cancer	☐ Developmental Delay
☐ Contagious Diseases	☐ Arthritis	☐ Seizures	☐ Hearing Loss
☐ Memory Loss	☐ Bleeding	☐ Diabetes	☐ Other_____

4 List Diagnosis_____

5 Treatment for Current Medical Problems/Diagnosis

_____

_____

_____

_____

6 **Current medications used by you or your spouse**

_____

_____

_____

7a **Have you or your spouse been hospitalized or gone to the Emergency Room within the last 12 months?** ☐ **Yes** ☐ **No**

7b **If yes, how many times?** _____ **Where?** _____

7c **Are you or your spouse going to have surgery in the next three months?** ☐ **Yes** ☐ **No**

7d **Are you or your spouse pregnant? If yes, due date:** _____ ☐ **Yes** ☐ **No**

Part B

8 **Where Do You Live?**

☐ At Home ☐ Other _____

☐ Community Based Organization

9 **Please Indicate Your or Your Spouse's Disability**

☐ Vision ☐ Behavior ☐ Hearing ☐ Judgement

☐ Mobility ☐ Memory ☐ Communication ☐ Other _____

10 **Please Indicate Any Durable Medical Equipment You or Your Spouse Use**

☐ Incontinence Devices ☐ Monitors ☐ Ostomy Supplies ☐ Wheelchair

☐ Diabetic Supplies ☐ Prosthetics ☐ Catheter Supplies ☐ Crutches/Walker/Cane

☐ Oxygen/Suctioning ☐ Other _____

11 **Treatment Procedures Currently Used**

☐ Tube Feeding ☐ Ventilator ☐ Catheter ☐ Preventive Care

☐ Oxygen/Trach ☐ Other _____

12 **Check All Programs You or Your Spouse Currently Participate In or Receive**

☐ Home Health ☐ DDD ☐ Personal Care Assistance

☐ DYFS ☐ ADDP ☐ Other _____

13 **Mental Health / Substance Abuse Services Used**

(Provider's Name)

_____

_____

_____

14 **Accommodations** Do you or your spouse need special accommodations?

(examples: Transportation, translator for language spoken other than English, a Signer, etc.)

If Yes, please identify type and frequency. ☐ Yes ☐ No

_____

_____

_____

15 **Sign Your HMO Plan Conversion Form**

Please sign and date below. *Before signing, read Statement of Understanding on the other side. Signing below means: you have read and understood both sides of this form; and, you give permission for the release of medical records as well as give us permission to give all information obtained here and in our interview (by phone or in person) to your health plan.*

_____

Signature (Relationship to Family Members) Date