



Applying for Services from the NJ Division of Developmental Disabilities

Application for Eligibility, including all signed forms and related documentation, must be mailed to the Community Services Office (CSO) that serves the Applicant’s county of residence (*see page 2 for CSO locations and counties served*).

- An individual must be **18 years of age or older to be evaluated by DDD for functional eligibility for services**
- An individual must be **21 years of age or older and be Medicaid eligible to receive services from DDD**

A. APPLICATION CHECKLIST

Any applicant who is 18 years of age or older and legally his/her own guardian must sign the required forms. If an applicant is receiving assistance completing the application, the person assisting should sign on the witness line.

- APPLICATION FOR ELIGIBILITY (5 pages)**
- NOTICE OF PRIVACY PRACTICES (6 pages):** *please read and keep for applicant’s records*
- ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (1 page):** *after reading the Notice of Privacy Practices, sign and return with application*
- AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS (2 pages):** *identifies people DDD can speak with regarding applicant’s health information – can include family members, health care professionals and emergency contacts; complete, sign and return with application*
- AUTHORIZATION FOR RELEASE OF RECORDS (2 pages):** *gives permission to people/organizations chosen by the applicant to send copies of health records to DDD; complete, sign and return with application*
- CONSENT FOR RELEASE OF INFORMATION TO DDD (1 page):** *for use with Section B documents – additional pages can be requested as needed; complete, sign and return with application*
- NEW JERSEY VOTER REGISTRATION FORM (1 page):** *an individual can choose to register to vote if he/she is 18 years of age or older; a U.S. citizen; a resident of New Jersey; and not currently serving a sentence or on probation or parole. Complete, sign and return with application.*

B. DOCUMENTATION OF DEVELOPMENTAL DISABILITY

Include as many of the available documents below as you are able that relate to the applicant’s developmental disability. The more documentation that is provided, the easier it is for DDD to process the application.

Necessary	Helpful But Not Necessary
Medical Documentation of Disability	Most recent IEP
Most Recent Psychological Evaluation (+ IQ Scores)	Speech Therapy Evaluations
Neurological Evaluations	Occupational Therapy Evaluations
Most Recent Child Study Team or School Reports	Physical Therapy Evaluations
Psychiatric Evaluations	Hospital Records
DVRS Assessments	Social Summaries
All Available Psychological Reports	

C. DOCUMENTATION OF MEDICAID ELIGIBILITY

Supplemental Security Income (SSI) annual award letter
Medicaid approval letter
Copy of Health Benefits Identification Card ("Medicaid" card)

If Applicant has encountered difficulty in obtaining Medicaid, contact DDD's Medicaid Eligibility Helpdesk:
 DDD.MediEligHelpdesk@dhs.state.nj.us

D. DOCUMENTATION OF AGE, US CITIZENSHIP, NJ RESIDENCY

(Note: applicant must be a permanent resident of New Jersey to apply for services through DDD)

1. Copy of Birth Certificate	
2. Copy of Social Security Card or Proof of U.S. Citizenship or Green Card	
3. Copy of one of the following:	<ul style="list-style-type: none"> —Current Photo Identification from NJ Motor Vehicle Commission —Pay Stub —W2 Form —Real Estate Tax Bill —Permanent Change of Station Orders to New Jersey (if individual's legal guardian is in the U.S. Military Service) —Voter Registration Form

E. OTHER DOCUMENTATION, if applicable

Copy of Guardianship Order
Division of Vocational Rehabilitation Services (DVRS) Records/Evaluations (F3 form)

F. NJ CAT ASSESSMENT

Once sections A-E have been provided to and reviewed by DDD, and all of the above information has been satisfied (up to and including face-to-face interview, if deemed appropriate by intake staff), the New Jersey Comprehensive Assessment Tool (NJ CAT) will be requested. The agency that administers the NJ CAT is the Developmental Disabilities Planning Institute (DDPI) at Rutgers.

DDD COMMUNITY SERVICES OFFICES

Counties Served	Office Location and Phone Number
Morris, Sussex, Warren	Flanders Office: 1 Laurel Drive Flanders, NJ 07836 Phone: 973.927.2600
Bergen, Hudson, Passaic	Paterson Office: 100 Hamilton Plaza, 7th Floor Paterson, NJ 07505 Phone: 973.977.4004
Essex	Newark Office: 153 Halsey St., 2nd FL, PO Box 47013, Newark, NJ 07101 Phone: 973.693.5080
Union, Somerset	Plainfield Office: 110 East 5th Street, Plainfield, NJ 07060 Phone: 908.226.7800
Ocean, Monmouth	Freehold Office: Juniper Plaza, Suite 1-J, 3499 Route 9 North, Freehold, NJ 07728 Phone: 732.863.4500
Hunterdon, Mercer, Middlesex	Trenton Office: 11A Quakerbridge Plaza, PO Box 705, Trenton, NJ 08619 Phone: 800.832.9173
Atlantic, Cape May, Cumberland, Salem	Mays Landing Office: 5218 Atlantic Avenue, Suite 205, Mays Landing, NJ 08330 Phone: 609.476.5200
Burlington, Camden, Gloucester	Voorhees Office: 2 Echelon Plaza, 221 Laurel Rd, Suite 210, Voorhees, NJ 08043 Phone: 856.770.5900

Applicant Information

Applicant Name: _____

Date of Birth: _____

Home Address: _____

Phone Number: _____

Email Address: _____

Application Completed By *(if not by completed by Applicant):*

Name: _____

Home Address: _____

Phone Number: _____

Email Address: _____

Can DDD contact you, if necessary, regarding this application? Yes No

Does the applicant have a Legal Guardian?* Yes No

***If yes, please complete the section below and provide a copy of the Guardianship Order with the application*

Legal Guardian Name: _____

Relationship to Applicant: _____

Address: _____

Phone Number: _____

Email Address: _____

(1) APPLICANT RESIDENCY AND OCCUPATION INFORMATION

Place of birth (hospital, city, state, or country if born outside the U.S.):

If born outside of the U.S., is Applicant a U.S. Citizen? Yes No

If No, does Applicant have a valid Green Card? Yes No

If Applicant has a legal guardian, is the legal guardian a permanent legal resident of New Jersey? Yes No

Is Applicant currently receiving services from any other federal, state or local agencies? Yes No

Agency Name: _____ Phone: _____

Address: _____

Agency Name: _____ Phone: _____

Address: _____

Agency Name: _____ Phone: _____

Address: _____

Does Applicant live in a Residential Program? Yes No

(For example, DCF, DCPP, Boarding Home, Homeless Shelter)

Residence Name: _____ Residence Type: _____

Address: _____

Does Applicant attend school or day program, and/or is Applicant employed? Yes No

Program Type: _____ Name: _____

Address: _____

Contact Name and Phone Number: _____

Program Type: _____ Name: _____

Address: _____

Contact Name and Phone Number: _____

Has the NJ Division of Vocational Rehabilitation Services (DVRS) assisted Applicant with employment or day services?

Yes No

(2) APPLICANT MEDICAID AND SOCIAL SECURITY BENEFIT INFORMATION

Does Applicant have Medicaid? Yes No

If not, has Applicant applied for Medicaid? Yes No

(To receive services through DDD, Applicant must obtain Medicaid. If Applicant has encountered difficulty in obtaining Medicaid, contact DDD's Medicaid Eligibility Helpdesk: DDD.MediEligHelpdesk@dhs.state.nj.us)

Does Applicant receive Social Security Disability Insurance (SSDI) benefits? Yes No

If yes, amount received per month: \$ _____

If no, what is SSDI application status? Never Applied Application Pending Ineligible

Does Applicant receive Supplemental Security Income (SSI) benefits? Yes No

If yes, amount received per month: \$ _____

If no, what is SSI application status? Never Applied Application Pending Ineligible

If Applicant receives SSDI or SSI, is there a Representative Payee? Yes No

Payee Name: _____ Benefit Type: _____

Address: _____ Phone: _____

Relationship to Applicant: _____

Payee Name: _____ Benefit Type: _____

Address: _____ Phone: _____

Relationship to Applicant: _____

(3) APPLICANT FAMILY AND HOUSEHOLD INFORMATION

Father: Living Deceased

If living, please complete the following:

Name: _____ Date of Birth: _____

Address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email Address: _____

Marital Status: _____

Is father a Veteran? Yes No

Is father an emergency contact? Yes No

Mother: Living Deceased

If living, please complete the following:

Name: _____ Date of Birth: _____

Address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email Address: _____

Marital Status: _____ Maiden Name, if applicable: _____

Is mother a Veteran? Yes No Is mother an emergency contact? Yes No

Other Members of Applicant's Household *(do not include parents if they are listed above)*

Name: _____

Date of Birth: _____ Relationship: _____

Name: _____

Date of Birth: _____ Relationship: _____

Name: _____

Date of Birth: _____ Relationship: _____



State of New Jersey
Department of Human Services
P.O. BOX 700
Trenton, NJ 08625-0700

NOTICE OF PRIVACY PRACTICES

Effective Date: October 15, 2018

This Notice applies to individuals receiving services from the Department of Human Services' (DHS) Division of Developmental Disabilities and does not require your response. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

YOUR RIGHTS

- **Right to see and copy your records.** In most cases, you have a right to view or get copies of your records. You must make your request in writing. We will provide a response to your request within thirty (30) days. You may be charged a fee for the cost of copying your records.
- **Right to an electronic copy of your medical records.** If your information is maintained in an electronic format, you may request that your electronic records be transmitted to you or another individual or entity. We will respond to your request within thirty (30) days.
- **Right to correct or update your records.** You may ask us to correct your health information if you think there is a mistake. You must make your request in writing and provide a reason for your need to correct the information.
- **Right to choose how we communicate with you.** You may ask us to share information with you in a certain way. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You don't have to explain a reason for the request. We may deny unreasonable requests.
- **Right to get a list of disclosures.** You have a right to ask us for a list of disclosures made after April 14, 2003. You must make a request in writing. This will not include information shared for treatment, payment or health operation purposes. We will provide one accounting a year free of charge, but may charge a cost for additional lists provided within the 12 month period.
- **Right to get notice of a breach.** You have a right to be notified upon a breach of any of your protected health information.
- **Right to request restrictions on uses or disclosures.** You have a right to ask us to limit how your information is used or shared with others. You must make the request in writing and indicate what information should be limited. We are not required to agree to a requested restriction. If you paid out-of-pocket expenses in full for a specific item or

service, you have a right to ask that your information with respect to that item or service not be disclosed. We will always honor that request.

- **Right to revoke authorization.** If we ask you to sign an authorization to use or disclose your information, you can cancel that authorization at any time. You must make that request in writing. Your request will not affect information that has already been shared.
- **Right to get a copy of this notice.** You have a right to ask for a paper copy of this notice at any time
- **Right to file a complaint.** You have a right to file a complaint if you don't agree with how we have used or disclosed your information.
- **Right to choose someone to act for you.** If someone has been legally designated as your personal representative, that person can exercise your rights and make choices about your health.

OUR DUTIES

The Department of Human Services functions as a health care provider for you and your family. Consequently, we must collect information about you to provide these services. We are required to protect your information according to federal and state law and will abide by the terms of this notice. We may use and disclose information without your authorization for the following purposes:

- **Treatment Purposes.** We may use or disclose your information to health care providers who are involved in your health care.
- **Payment.** We may use or disclose your information to get payment or pay for health care services you received or will receive.
- **Health Care Operations.** We may use or disclose your information in order to manage our business, improve your care and contact you when necessary.
- **As Required by Law.** We will disclose information to a public health agency that maintains vital records, such as births, deaths and some diseases.
- **Abuse and Neglect Investigations.** We may disclose your information to report all potential cases of abuse and/or neglect.
- **Health Oversight Activities.** We may use or disclose your information to respond to an inspection or investigation by state officials.
- **Government Programs.** We may use and disclose your information for the management and coordination of public benefits under government programs.
- **To Avoid Harm.** We may use and disclose information to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

- **For Research.** We may use and disclose your information for studies and to develop reports. These reports will not specifically identify you or another person.
- **Business Associates.** We may use and disclose your information to our business associates that perform functions on our behalf, if necessary to complete those functions.
- **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose your information to organizations engaged in procuring, banking or the transportation of organs, eyes, or other tissues to facilitate organ transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose your information to the appropriate military authority.
- **Workers Compensation.** We may use or disclose your information for workers compensation or similar programs providing benefits for work-related injuries or illnesses.
- **Data Breach Notification Purposes.** We may use or disclose your information to provide legally required notices of unauthorized access or disclosure of your health information.
- **Lawsuits and Disputes.** We may use or disclose your information in response to a Court or Administrative Order, subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose your information to law enforcement if the information: 1) is in response to a court order, subpoena, warrant or similar process; 2) limited to identify or locate a suspect, fugitive, material witness or missing person; 3) about a victim of a crime under very limited circumstances; 4) about a death potentially resulting from a crime; 5) about criminal conduct on any DHS property and; 6) is needed in an emergency to report a crime or facts surrounding a crime.
- **Coroner, Medical Examiners and Funeral Directors.** We may disclose your information to a Coroner or Medical Examiner to identify a deceased person or determine the cause of death. We may release your information to a Funeral Director as necessary for their duties.
- **National Security and Intelligence.** We may disclose your information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose your information to authorized federal officials so that they can provide protection to the U.S. President; other authorized persons or foreign heads of state, or to conduct special investigations.
- **Inmates or Individuals in Custody.** If you are an inmate, we may release your information to a correctional institution if that information would be necessary for the institution to: 1) provide you with health care; 2) protect your health and safety or the health and safety of others or: 3) for the safety and security of the correctional institutions.

- **Disclosure to Family, Friends and Others.** We may disclose your information to your family members, friends or other persons who are involved in your medical care. You may object to the sharing of this information. We may also share your information with someone legally designated as your personal representative.
- **Hospital Directory.** Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital.

Other Uses and Disclosures that Require Your Written Authorization

- **For All Other Situations.** We will ask for your written authorization before using or disclosing information for any other purpose than what is mentioned above. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes and for the sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, please contact us at the number below. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.
- **As Required by Other Laws.** We will ask for your written authorization to comply with other laws protecting the use and disclosure of your information.

FILING A COMPLAINT

To file a complaint or report a problem regarding the use or disclosure of your health information, use the contact information below. Treatment or services being provided to you will not be affected by any complaints you make. DHS opposes retaliatory acts resulting from participation in a HIPAA investigation.

New Jersey Department of Human Services
 Division of Developmental Disabilities
 Legal and Administrative Practice Office
 P.O. Box 726
 222 South Warren St.
 Trenton, NJ 08625-0726
 Phone: 609-633-7402

U.S. Department of Health and Human Services
 Office of Civil Rights
 200 Independence Ave, S.W., Room 509H
 Washington DC, 20201
 Phone: 866-627-7748/ TTY: 886-788-4989
www.hhs.gov/ocr

DHS or its appropriate Division will respond to your communication within 30 days.

CHANGES TO THIS NOTICE

In the future, DHS may change its Notice of Privacy Practices. Any change could apply to medical information we already have about you, as well as information we receive in the future. A copy of a new notice will be posted in our facilities/offices and provided to you as required by law. You may ask for a copy of our current notice or get it online on our website.

New Jersey Department of Human Services
DIVISION OF DEVELOPMENTAL DISABILITIES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This **ACKNOWLEDGEMENT OF RECEIPT** must be signed upon receipt of the Notice of Privacy Practices and returned to the New Jersey Division of Developmental Disabilities.

I, _____ (print name)

Hereby acknowledge that I received the **Notice of Privacy Practices** on _____
(date)

I am: *(please check one)*

Applicant

Parent

Legal Guardian

Applicant, Parent or Legal Guardian Signature or Mark*

Date

If signed by Legal Guardian:

Applicant Name (please print)

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable

Witness Name (please print)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name: _____

Date of Birth: _____

1. Person(s) authorized to use, disclose or receive information *(include legal guardian if applicable)*:

PRIMARY CONTACT	ALTERNATE CONTACT
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Alternate Phone: _____	Alternative Phone: _____
Relationship: _____	Relationship: _____
OTHER CONTACT	OTHER CONTACT
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Alternate Phone: _____	Alternative Phone: _____
Relationship: _____	Relationship: _____

2. I authorize DDD staff to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization.
3. I authorize DDD staff to provide the minimum necessary health information to the contacts listed above and/or other individuals who are permitted to visit.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.
7. This authorization expires on _____ or one year from the date of the individual's/legal guardian's signature.
8. A complete copy of this form will be maintained in the applicant's record.
9. **To Legal Guardians:** If the individual receiving/applying for services is 18 years of age or older and you have indicated that you are the individual's Legal Guardian, then you must attach a copy of a valid **Appointment of Guardianship** to this form.

Individual or Legal Guardian Signature or Mark*

Date

Legal Guardian Name, if applicable (please print)

Please attach a valid Appointment of Guardianship to this form, if applicable

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable

Witness Name (please print)

Legal Authority for this Request:

- These are my records, and I am a legally competent adult.
- I am the Legal Guardian of the individual whose records are being requested. *A copy of valid Appointment of Guardianship is attached.*
- I am a parent of the individual whose records are being requested and I have Power of Attorney for the individual, which authorizes me to be able to request the individual’s medical records. *A copy of valid Power of Attorney is attached.*

Understandings and Agreements about this Authorization:

1. This authorization is voluntary and I understand that DDD cannot condition treatment based on the signing of this authorization, unless the authorization is: (a) for research-related treatment, or (b) solely for the purpose of creating health information for use by/disclosure to a third party.
2. This authorization will expire on _____ (date to be determined by person signing this form) or one year from the date of my signature below.
3. I understand I may revoke this authorization at any time by notifying DDD in writing, and my written revocation will not have any effect on any actions taken prior to the time DDD received the written revocation.
4. I agree to waive all claims against the DDD facility/agency for release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by DDD if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or business associate that has a contract with DDD.
6. I understand that if I request that records be copied and sent to me, DDD will make a good faith effort to send those records to me within a reasonable timeframe.
7. I understand that if I wish to have copies of the records made, DDD may assess a fee for copying the records.

Signature (or mark*) of Individual, Legal Guardian or Power of Attorney (please circle one) making this Request

Date **Phone Number**

Name of Person Making this Request (please print): _____

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable

Witness Name (please print)

If Requestor is the Legal Guardian or Power of Attorney for the Individual, a copy of valid Appointment of Guardianship or Power of Attorney must be attached.

New Jersey Department of Human Services
DIVISION OF DEVELOPMENTAL DISABILITIES

**CONSENT FOR RELEASE OF INFORMATION
TO THE NJ DIVISION OF DEVELOPMENTAL DISABILITIES**

I, _____
(Individual, Legal Guardian or Power of Attorney Name)

Do hereby grant permission for _____
(Name of individual, institution, agency, or other holder of requested information)

To release the report(s), evaluations(s), summaries or other information described below regarding the Application for Eligibility for services through the NJ Division of Developmental Disabilities of:

Applicant Name (please print): _____

Information to be released:

Information is to be released to:

_____, Intake Worker

NJ Division of Developmental Disabilities

Signature or Mark*: _____ Date: _____

If other than applicant, relationship to applicant: _____

****If mark is provided in place of signature, the mark must be witnessed:***

Witness Signature, if applicable: _____

Witness Name (please print): _____

The information received through this release is subject to the confidentiality regulations of the Division and cannot be released outside the Division without written permission unless otherwise provided by N.J.A.C. 10:41et seq.



New Jersey Voter Registration Application

Please print clearly in ink. All information is required unless marked optional.

1 Check boxes that apply: <input type="checkbox"/> New Registration <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Signature Update or Non-affiliation Change <input type="checkbox"/> Political Party Affiliation <input type="checkbox"/>						FOR OFFICIAL USE ONLY	
2 Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, DO NOT complete this form)		Are you at least 17 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, DO NOT complete this form)		Clerk			
3 Last Name		First Name	Middle Name or Initial	Suffix (Jr., Sr., III)			Registration #
4 Date of Birth							Office Time Stamp
5 NJ Driver's License Number or MVC Non-driver ID Number			If you DO NOT have a NJ Driver's License or MVC Non-Driver ID, provide the last 4 digits of your Social Security Number. ____ ____ ____ ____				
<input type="checkbox"/> "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."							
6 Home Address (DO NOT use PO Box)		Apt.	Municipality	County	State		
7 Mailing Address if different from above		Apt.	Municipality	County	State		Zip Code
8 Last Address Registered to Vote (DO NOT use PO Box)		Apt.	Municipality	County	State		Zip Code
							<input type="checkbox"/> by mail <input type="checkbox"/> in person
9 Former Name if Making Name Change			a. Day Phone Number (Optional) _____				
			b. E-Mail Address (Optional) _____				
10 Do you wish to declare a political party affiliation? (Optional) <input type="checkbox"/> Yes, the party name is _____ <input type="checkbox"/> No, I do not wish to be affiliated with any political party.							
11 Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Declaration - I swear or affirm that: <input checked="" type="checkbox"/> I am a U.S. Citizen <input checked="" type="checkbox"/> I live at the above address <input checked="" type="checkbox"/> I am at least 17 years old, and understand that I may not vote until reaching the age of 18.		<input checked="" type="checkbox"/> I will have resided in the State and county at least 30 days before the next election <input checked="" type="checkbox"/> I am not on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws		<input checked="" type="checkbox"/> I understand that any false or fraudulent registration may subject me to a fine of up to \$15,000, imprisonment up to 5 years, or both pursuant to R.S. 19:34-1		
Signature: Sign or mark and date on lines below X _____ Date _____				If applicant is unable to complete this form, print the name and address of individual who completed this form. Name _____ Date _____ Address _____			

Important Instructions for sections 5, 6 and 10

5) Registrants who are submitting this form by mail and are registering to vote for the first time: If you do not have any of the information required by section 5, or the information you provide cannot be verified, you will be asked to provide a COPY of a current and valid photo ID, or a document with your name and current address on it to avoid having to provide identification at the polling place.

Note: ID Numbers are Confidential and will not be released by any governmental agency. Any person who uses such numbers illegally shall be subject to criminal penalties.

6) If you are homeless, you may complete section 6 by providing a contact point or the location where you spend most of your time.

10) You may declare a political party affiliation or you may declare to be unaffiliated, regardless of any prior party affiliation. If you are a previously affiliated voter who wants to change political party affiliation or become unaffiliated, you must file this form no later than 55 days before the primary election in order to vote in the primary election. Completing section 10 is OPTIONAL and will not affect the acceptance of your voter registration application.

Need More Information? Check boxes below if you would like to receive more information about:

- voting by mail
- becoming a poll worker
- polling place accessibility
- voting if you have a disability, including visual impairment
- available election materials in this alternative language:

For further information visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)



New Jersey Voter Registration Information

You can register to vote if:

- You are a United States citizen.
- You are at least 17 years of age.*
- You will be a resident of the State and county 30 days before the election.
- You are **NOT** currently serving a sentence, probation or parole because of a felony conviction.

*You may register to vote if you are at least 17 years old but cannot vote until reaching the age of 18.

Registration Deadline: 21 days before an election

Your County Commissioner of Registration will notify you if your application is accepted. If it is not accepted, you will be notified on how to complete and/or correct the application.

Questions? visit Elections.NJ.gov or call toll-free 1-877-NJVOTER (1-877-658-6837)

1 FOLD



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 206 TRENTON, NJ

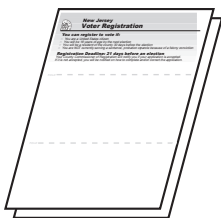
POSTAGE WILL BE PAID BY ADDRESSEE

DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

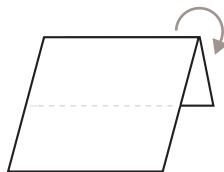


2 FOLD

Important: Print out at 100% - DO NOT REDUCE. Fold as illustrated to ensure proper mailing.



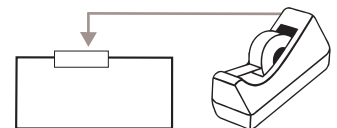
Put both pages
together as shown



1 fold top down



2 fold bottom up



3 Tape top shut

HERE TAP **3**