NJ DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

Application for Determination of Eligibility for Services

Applicant is age 18 or older and WAS NOT previously determined eligible for developmental disability services through DCF-CSOC / PerformCare

FULL Application for Eligibility is **REQUIRED**

Applicant is age 18 or older and WAS previously determined eligible for developmental disability services through DCF-CSOC / PerformCare

SHORT Application for Eligibility may be submitted

Enclosed is the DDD

FULL Application

If you are not sure if the applicant was previously determined eligible for developmental disability services through DCF-CSOC/PerformCare, **contact PerformCare at 1-877-652-7624**.

Students age 16 – 21 and their families are encouraged to review DDD's **Graduates Timeline**:
www.nj.gov/humanservices/ddd/documents/graduates-timeline.pdf

APPLICATION INSTRUCTIONS

- The application can be completed by an individual who is 18 or older, or by a guardian or representative acting on behalf of an individual who is 18 or older.

- An applicant who is 18 or older and legally their own guardian must sign the application and forms. (If an applicant is receiving assistance completing the application, the person assisting should sign on the witness line.)

- The signed application and forms and any required documentation **MUST BE MAILED** to the DDD Community Services Office (CSO) that serves the applicant's county of residence (*see table below*).

- If you have questions about the application or need assistance completing it, please contact the Intake Unit of the Community Services Office for your county.

Counties Served	CSO 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
Somerset Union	**PLAINFIELD OFFICE:** 110 East 5th Street, Plainfield, NJ 07060 Phone: 908.226.7800
Monmouth Ocean	**FREEHOLD OFFICE:** Juniper Plaza, Suite 1-J, 3499 Route 9 North, Freehold, NJ 07728 Phone: 732.863.4500
Hunterdon Mercer Middlesex	**TRENTON OFFICE:** PO Box 705, Trenton, NJ 08625 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

FULL APPLICATION – WHAT IS NEEDED

A. APPLICATION AND FORMS

- **FULL APPLICATION** (5 pages)
- **NOTICE OF PRIVACY PRACTICES** (4 pages – keep for your records)
- **FORM A: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** (1 page)
- **FORM B: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION** (2 pages)
- **FORM C: AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS** (2 pages)
- **FORM D: CONSENT FOR RELEASE OF INFORMATION TO DDD** (1 page)
- **NEW JERSEY VOTER REGISTRATION OPPORTUNITY** (1 page)
- **NEW JERSEY VOTER REGISTRATION APPLICATION** (2 pages)

B. DOCUMENTATION OF DEVELOPMENTAL DISABILITY

Include as many of the documents below as possible 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

- Medical Documentation of Disability
- Most Recent Psychological Evaluation (+ IQ Scores)
- Neurological Evaluations
- Most Recent Child Study Team or School Reports
- Psychiatric Evaluations
- DVRS Assessments
- All Available Psychological Reports

Helpful But Not Necessary

- Most recent IEP
- Speech Therapy Evaluations
- Occupational Therapy Evaluations
- Physical Therapy Evaluations
- Hospital Records
- Social Summaries

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)

- Copy of Birth Certificate
- Copy of Social Security Card *or* Proof of U.S. Citizenship *or* Green Card
- Copy of **one** of the following:
  - Current Photo Identification from NJ Motor Vehicle Commission
  - Pay Stub
  - W2 Form
  - Real Estate Tax Bill (only if the applicant owns property)
  - Permanent Change of Station Orders to New Jersey (if individual's legal guardian is in the U.S. Military Service)
  - Voter Registration Acknowledgement Card

E. OTHER DOCUMENTATION, *if applicable*

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

F. NJCAT ASSESSMENT

After DDD has received and reviewed the application and documentation, and the above information has been satisfied (up to and including face-to-face interview, if deemed appropriate by intake staff), DDD will schedule the individual for a New Jersey Comprehensive Assessment Tool (NJCAT).

FULL* APPLICATION FOR DETERMINATION OF ELIGIBILITY

***For use when an individual is 18 or older and HAS NOT previously been determined eligible for developmental disability services through the Department of Children and Families—Children's System of Care (DCF-CSOC)/PerformCare.**

SECTION 1: APPLICANT DECLARATION

In accordance with the Revised Statute, State of New Jersey, Section 30:4-25.2, an application is being made to the Commissioner of the Department of Human Services for a determination of eligibility for services provided through the NJ Division of Developmental Disabilities (DDD) for:

Applicant Name: _____ _____
First Last

Date Birth: _____

BY SIGNING THIS APPLICATION, I AM DECLARING THAT:

1. This Application for Determination of Eligibility and all forms submitted with it have been completed as accurately as possible.
2. I understand that I have the opportunity to appeal a determination of ineligibility in accordance with N.J.A.C. 10:48-1.1(j).

This application is being made under R.S. 30:4-25.2 by virtue of the relationship to the above Applicant:

___ SELF ___ LEGAL GUARDIAN OF THE APPLICANT ___ COURT OF COMPETENT JURISDICTION

Applicant/Legal Guardian Signature (or mark): _____ Date: _____

Witness Name (please print): _____

Witness Signature: _____ Date: _____

Witness Title (if agency or court representative): _____

FOR DDD USE ONLY – Applicant please proceed to Section 2

Functional Criteria Met: ___ YES ___ NO Closed due to insufficient information: ___ YES ___ NO

Medicaid eligible: ___ YES ___ NO

DDD Staff Signature: _____ Date: _____

DDD Staff Title/Unit: _____

DDD Staff Signature: _____ Date: _____

DDD Staff Title/Unit: _____

SECTION 2: APPLICANT INFORMATION AND GUARDIANSHIP STATUS

APPLICANT INFORMATION

Applicant Name: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

Email Address: _____

APPLICATION COMPLETED BY (if not by completed by Applicant):

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

Email Address: _____

Can DDD contact you, if necessary, regarding this application? ___ YES ___ NO

GUARDIANSHIP STATUS*

Does Applicant have a legal guardian? ___ YES ___ NO

If **YES**, *please complete:*

Legal Guardian Name: _____ Date of Birth: _____

Relationship to Applicant: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

Email Address: _____

***If Applicant has a legal guardian, Guardianship Order must be included.**

SECTION 3: APPLICANT CITIZENSHIP AND OCCUPATION INFORMATION

CITIZENSHIP INFORMATION

Place of Birth (hospital and state OR country if outside US): _____

New Jersey Resident Since (Date): _____

1. Is Applicant a U.S. Citizen? ___ YES ___ NO
2. If No, does Applicant have a valid Green Card? ___ YES ___ NO
3. If Applicant has a legal guardian, is the legal guardian a permanent legal resident of New Jersey? ___ YES ___ NO

OCCUPATION INFORMATION

1. Is Applicant receiving services from any other federal, state or local agencies? ___ YES ___ NO

If **YES**, *please provide information:*

Agency Name: _____

Address: _____ Phone: _____

Agency Name: _____

Address: _____ Phone: _____

Agency Name: _____

Address: _____ Phone: _____

2. Is Applicant attending school? ___ YES ___ NO
3. Is Applicant employed? ___ YES ___ NO

If **YES to either**, *please provide information:*

School Name: _____

School Address: _____

School Contact Name: _____ Contact Phone: _____

Employer Name: _____

Employer Address: _____

Employer Contact Name: _____ Contact Phone: _____

4. Has NJ Division of Vocational Rehabilitation assisted Applicant with employment/day services? ___ YES ___ NO

5. Does Applicant live in a residential program? (*e.g., DCF, DCPP, Boarding Home, Homeless Shelter*) ___ YES ___ NO

If **YES**, *please provide information:*

Residence Name: _____ Residence Type: _____

Address: _____ Phone: _____

SECTION 4: APPLICANT MEDICAID AND SOCIAL SECURITY BENEFIT INFORMATION

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

1. Does Applicant have Medicaid? ___ YES ___ NO
2. If NO, has Applicant applied for Medicaid? ___ YES ___ NO
3. Does Applicant receive Social Security Disability Insurance (SSDI) benefits? ___ YES ___ NO

   If YES, monthly amount: $ _____

   If NO, what is SSDI application status? ___ NEVER APPLIED ___ APPLICATION PENDING ___ INELIGIBLE
4. Does Applicant receive Supplemental Security Income (SSI) benefits? ___ YES ___ NO

   If YES, monthly amount: $ _____

   If NO, what is SSI application status? ___ NEVER APPLIED ___ APPLICATION PENDING ___ INELIGIBLE
5. If Applicant receives SSDI or SSI, is there a Representative Payee? ___ YES ___ NO

If **YES**, *please provide information:*

REPRESENTATIVE PAYEE FOR SSI BENEFIT

Payee Name: _____ Relationship to Applicant: _____

Address: _____ Phone: _____

REPRESENTATIVE PAYEE FOR SSDI BENEFIT

Payee Name: _____ Relationship to Applicant: _____

Address: _____ Phone: _____

SECTION 5: APPLICANT'S FAMILY

APPLICANT'S PARENT #1

Applicant's parent #1 is: ___ LIVING ___ DECEASED (*If Deceased, no information is needed*)

Parent #1 Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent #1 marital status: ___ MARRIED ___ DIVORCED ___ WIDOWED ___ NEVER MARRIED

Is parent #1 a U.S. military veteran? ___ YES ___ NO Is parent #1 an emergency contact? ___ YES ___ NO

APPLICANT'S PARENT #2

Applicant's parent #2 is: ___ LIVING ___ DECEASED (*If Deceased, no information is needed*)

Parent #2 Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent #2 marital status: ___ MARRIED ___ DIVORCED ___ WIDOWED ___ NEVER MARRIED

Is parent #2 a U.S. military veteran? ___ YES ___ NO Is parent #2 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 to Applicant: _____

Name: _____ Date of Birth: _____

Relationship to Applicant: _____

Name: _____ Date of Birth: _____

Relationship to Applicant: _____

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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.

FORM A: 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 NJ Division of Developmental Disabilities.

I (applicant or legal guardian), _____

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

I am the (please check one): ___ Applicant ___ Legal Guardian

Signature (or mark): _____ Date: _____

If signed by Legal Guardian, please provide Applicant's name:

Applicant Name (please print): _____

If Applicant mark is provided, a witness is required:

Witness Signature: _____ Date: _____

Witness Name (please print): _____

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FORM B: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I, _____

(Individual, Legal Guardian or Power of Attorney Name)

Do herby authorize the use/disclosure/receipt of health information about the Applicant named below:

First Name: _____ Last Name: _____

Date of Birth: _____

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

PRIMARY CONTACT: _____ Phone: _____

Address: _____

Relationship to Applicant: _____ Email: _____

ALTERNATE CONTACT: _____ Phone: _____

Address: _____

Relationship to Applicant: _____ Email: _____

OTHER CONTACT: _____ Phone: _____

Address: _____

Relationship to Applicant: _____ Email: _____

OTHER CONTACT: _____ Phone: _____

Address: _____

Relationship to Applicant: _____ Email: _____

1. 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.
2. 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.

3. 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.

4. 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.

5. 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.

6. This authorization expires on (date) _____ or one year from the date of the individual/legal guardian's signature.

7. A complete copy of this authorization will be maintained in the applicant's record.

Signature or mark of (select one): ___ Individual ___ Legal Guardian ___ Power of Attorney

Signature*: _____ Date: _____

Phone: _____

If mark is provided, a witness is required:

Witness Signature: _____ Date: _____

Witness Name (please print): _____

***If signed by Legal Guardian or Power of Attorney, Guardianship Order or Power of Attorney Order must be included.**

FORM C: AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____ (DDD facility/office) of the Division of Developmental Disabilities to release the individually identifiable health information/medical records as described below.

Requestor's Name: _____

Requestor's Address: _____

Medical records of the individual named below are being requested:

First Name: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____

The requested medical records were created between:

Beginning Date: _____ and Ending Date: _____

Medical Records requested:

_____

_____

Medical Records to be used for the following purpose(s):

_____

_____

___ Requested medical records will be reviewed at the DDD facility/office.

___ Requested medical records should be copied and will be picked up at the DDD facility/office.

___ Requested medical records should be copied and sent to the person or organization below:

Name: _____

Address: _____

City, State, Zip Code: _____

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 and **a copy of the Guardianship Order is attached**.

___ I have Power of Attorney for the individual whose records are being requested and **a copy of the 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. 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.
3. I agree to waive all claims against the DDD facility/office for release of the requested information.
4. 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.
5. 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.
6. I understand that if I wish to have copies of the records made, DDD may assess a fee for copying the records.
7. This authorization will expire on _____ (date is determined by person signing the form) or one year from the date of signature below.

Signature or mark of (select one): ___ Individual ___ Legal Guardian ___ Power of Attorney:

Signature*: _____ Date: _____

Phone: _____

If mark is provided, witness is required:

Witness Signature: _____ Date: _____

Witness Name (please print): _____

***If signed by Legal Guardian or Power of Attorney, Guardianship Order or Power of Attorney Order must be included.**

FORM D: CONSENT FOR RELEASE OF INFORMATION TO THE NJ DIVISION OF DEVELOPMENTAL DISABILITIES

I, _____

(Individual, Legal Guardian or Power of Attorney Name)

Do herby 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 of the individual named below below regarding their Application for Eligibility for services through the NJ Division of Developmental Disabilities:

Applicant Name (please print): _____

Information to be released:

_____

_____

_____

Information is to be released to the DDD Intake Worker and address named below:

DDD Intake Worker Name: _____

DDD Intake Office Address:

_____

_____

_____

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.

Signature or mark of (select one): ___ Individual ___ Legal Guardian ___ Power of Attorney:

Signature*: _____ Date: _____

Phone: _____

*If mark is provided, witness is required:

Witness Signature: _____ Date: _____

Witness Name (please print): _____

***If signed by Legal Guardian or Power of Attorney, Guardianship Order or Power of Attorney Order must be included.**

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State of New Jersey
Department of State
Division of Elections

Voter Registration Opportunity

The National Voter Registration Act of 1993 requires the State to provide you with the opportunity to register to vote as an additional service offered by this office. Please complete the form below to advise the agent of your interest to register or not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you decline to register to vote at this time, your decision will remain confidential and will be used only for voter registration purposes. If you do register to vote, the way in which you do so will remain confidential and will be used only for voter registration purposes.

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 of incarceration as the result of a conviction of any indictable offense under the laws of this or another state or of the United States.

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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NJ Division of Elections

Mailing Address:	**Office Location**
P.O. Box 304	20 West State Street, 4th Floor
Trenton, NJ 08625-0304	Trenton, NJ 08608

Tel: 609-292-3760 Fax: 609-777-1280
TTY: 1-800-292-0034
Elections.NJ.gov

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes ☐ No ☐ No, I am already registered at my current address

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

_____ _____ _____
Print Name Signature Date

For Official Use
RTS ☐
_____Initial

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New Jersey
Voter Registration Application

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

1 Check all boxes that apply: ☐ New Registration ☐ Name Change ☐ Political Party Affiliation ☐ Address Change ☐ Signature Update ☐ Vote By Mail

2 Are you a U.S. Citizen? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

3 Are you at least 17 years of age? ☐ Yes ☐ No *(If No, DO NOT complete this form)*

4 Last Name | First Name | Middle Name or Initial | Suffix *(Jr., Sr., III)*

5 Date of Birth *(MM / DD / YYYY)* / /

6 Gender ***(Optional)*** ☐ Female ☐ Male

7 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. ___ ___ ___ ___

☐ "I swear or affirm that I DO NOT have a NJ Driver's License, MVC Non-driver ID or a Social Security Number."

8 Home Address *(DO NOT use PO Box)* | Apt. | Municipality *(City/Town)* | County | State | Zip Code

9 Mailing Address *(If different from Home Address)* | Apt. | Municipality *(City/Town)* | County | State | Zip Code

10 Last Address Registered to Vote *(DO NOT use PO Box)* | Apt. | Municipality *(City/Town)* | County | State | Zip Code

11 Former Name if Making Name Change

12 Day Phone Number ***(Optional)*** _____

E-Mail Address ***(Optional)*** _____

13 Do you wish to declare a political party affiliation? ***(Optional)***

☐ Yes, the party name is _____

☐ No, I do not wish to be affiliated with any political party.

FOR OFFICIAL USE ONLY

Clerk

Registration #

Office Time Stamp

☐ by mail
☐ in person

Muni Code #

Party

Ward

District

14 Request for Mail-In Ballot for all future elections ***(Optional)***

☐ I wish to receive a Mail-In Ballot for all future elections until I request otherwise in writing to the County Clerk's office.

☐ Mail my ballot to the following address if different from Mailing Address above.

Mailing Address if different from above | Apt. | Municipality *(City/Town)* | State | Zip Code

Declaration - I swear or affirm that:

- I am a U.S. Citizen
- I live at the above home address
- I am at least 17 years old, and understand that I may not vote until reaching the age of 18
- I will have resided in the State and county at least 30 days before the next election
- I am not serving a sentence of incarceration as the result of a conviction of any indictable offense under the laws of this or another state or of the United States.
- 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 of Registrant: Sign or mark and date on lines below

x _____ Date ___/___/___ *(MM / DD / YYYY)*

If applicant is unable to complete this form, print the name and address of individual who completed this form.

Name _____

Date *(MM / DD / YYYY)* ___/___/___

Address _____

Important Instructions for sections 7, 8, 13 and 14

7) Registrants who are submitting this form by mail and are registering to vote for the first time: If you do not supply any of the information required by section 7, 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.*

8) If you are homeless, you may complete section 8 by providing a contact point or the location where you spend most of your time.

13) 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 13 is OPTIONAL and will not affect the acceptance of your voter registration application.

14) If you wish to receive a Mail-In Ballot for all future elections, mark the appropriate box in section 14. You will continue to receive Mail-In Ballots for all future elections until you request otherwise in writing to your County Clerk's office.

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

☐ voting by mail ☐ polling place accessibility ☐ voting if you have a disability, including visual impairment

☐ becoming a poll worker ☐ available election materials in this alternative language: _____

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.
- I am not serving a sentence of incarceration as the result of a conviction of any indictable offense under the laws of this or another state or of the United States.

**Y*ou 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

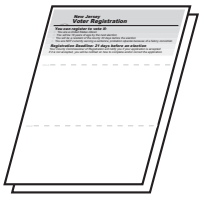
BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 206 TRENTON, NJ

POSTAGE WILL BE PAID BY ADDRESSEE

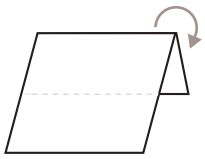
DIVISION OF ELECTIONS
PO BOX 304
TRENTON NJ 08625-9983

2 FOLD

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

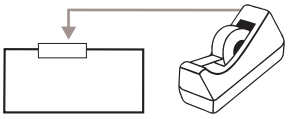


Put both pages together as shown



1 fold top down

2 fold bottom up



3 Tape top shut

3 TAPE HERE