New Jersey Department of Children and Families
Division of Children's System of Care

#2 - Applicant Information Form

Please provide as much information as possible. Attach additional sheets as necessary.

Applicant Name_____ Form Completed by_____

Date of Birth _____ Relationship to Applicant_____

Social Security # _____ Date completed_____

Applicant's Primary Address: _____

_____

_____

_____

Phone: _____ E-mail_____

Does Applicant have a Legal Guardian? ____ Yes _____No If yes, please complete:

Name: _____ Phone #:_____

Address: _____

1. APPLICANT RESIDENCY INFORMATION

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

_____

_____

If born outside U.S., is Applicant a U.S. citizen? _____ Yes _____ No

If No, is Applicant a permanent alien resident? _____Yes _____ No

Are parents/legal guardian permanent legal residents of New Jersey?

_____ Yes _____ No

Is Applicant currently receiving services from any agency in any state other than New Jersey?

_____Yes _____ No If yes:

_____ _____ _____

Name of Agency Address Phone #

Does Applicant Reside in a Residential Program? _____Yes _____ No If yes, please complete:

Treatment Type: _____

Provider Name: _____

Does Applicant Attend a Day Program or School? _____Yes _____No If yes, please complete:

Type of Program: _____ Phone # _____

Name of Program/School: _____

Address: _____

2. APPLICANT INSURANCE AND BENEFIT INFORMATION

Does Applicant have or receive:

- Medicaid? _____Yes _____No If yes, Medicaid Number_____
  (Note: This is not the number on your Medicaid card. If necessary, call N.J. Medicaid at 800-356-1561 and ask for it.)
- Private Insurance? _____Yes _____No If yes, please list: Policy Name:_____

Policy Number: _____ Telephone Number: _____

- Social Security Administration Death or Disability (SSA/SSDI) benefits? _____Yes _____ No
- If yes: Claim # _____ and amount received per month: $ _____
- If no: _____ Never applied _____ Application pending _____Ineligible
- Supplemental Security Income (SSI) benefits? _____Yes _____No
- If yes: Claim # _____ and amount received per month $ _____
- If no: _____Never applied _____ Application pending _____Ineligible
- If Applicant receives SSA/SSDI or SSI, is there a Representative Payee? _____Yes _____No
- If yes, please complete:

Benefit	Name	Address	Phone	Relationship

Is Applicant requesting an immediate residential treatment funded by CSOC? ____ Yes _____No

- **If no, please skip sections 2a and 2b, and move to Section 3.**
- **If yes, please complete sections 2a, 2b, and 3.**

2a. FOR ALL APPLICANTS REQUESTING A CSOC-FUNDED RESIDENTIAL TREATMENT: OTHER BENEFITS AND ASSETS OWNED OR RECEIVED BY APPLICANT

Include Salary, Bank Accounts, Trust Accounts, Stocks & Bonds, Malpractice Accounts, Pensions, Alimony, Veteran's Benefits, Railroad Retirement Benefits, etc. Attach separate sheet if necessary.

Account/Benefit Name	Address	City/State/Zip	Account/Claim #	Balance or Amt. Rec./Month

Representative Payee: Who is Representative Payee for these benefits or assets? Please list below:

Benefit Or asset	Name	Address	City/State/Zip	Phone	Relationship

2b. FOR APPLICANTS UNDER 18 REQUESTING A CSOC-FUNDED RESIDENTIAL TREATMENT: BENEFITS AND ASSETS OWNED OR RECEIVED BY PARENTS

Please show all assets or sources of income personally owned by or received by Parents of Applicant, such as Parents' Salaries, Bank Accounts, Trust Accounts, Stocks & Bonds, Malpractice Accounts, Veteran's Benefits, Railroad Retirement Income, Pensions, etc.

Father

Account/Benefit Or Employer Name	Address	City/State/Zip	Account/Claim #	Balance or Amt. Rec./Month

Mother

Account/Benefit Or Employer Name	Address	City/State/Zip	Account/Claim #	Balance or Amt. Rec./Month

3. APPLICANT FAMILY AND HOUSEHOLD INFORMATION

Father: _____Living _____Deceased If living, please complete the following:

Name_____ Date of Birth: _____

Address, if different from Applicant: _____

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

E-mail: _____

Social Security #:_____Veteran? _____Yes _____No

Marital Status _____ Is Father an Emergency Contact? _____Yes _____No

Mother: _____ Living _____Deceased If living, please complete the following:

Name_____ Date of Birth: _____

Address, if different from Applicant: _____

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

E-mail: _____

Social Security #: _____ Veteran? _____Yes _____No

Marital Status _____

Marital Status/Maiden Name: _____ Is Mother an Emergency Contact? ____Yes ___ No

Other Members of Applicants Household (Do not include parents if they are listed above)

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Immediate Family Members Who Do Not Reside with Applicant (Do not include parents if listed above)

Name _____ DOB _____Relationship_____

Address: _____ Phone #:_____

Name _____ DOB _____Relationship_____

Address: _____ Phone #:_____

4. EMERGENCY CONTACT INFORMATION *if different from, or in addition to, parents or guardian*

Name _____Phone #_____ Relationship_____

Name _____ Phone # _____ Relationship _____