Attach A
Rev. 2, 7/31/02

HUNTERDON COUNTY DEPARTMENT OF HUMAN SERVICES
CONSOLIDATED
SERVICE/INCOME ELIGIBILITY APPLICATION

RETURN TO:

Hunterdon County Department of Human Services
PO Box 2900
Flemington, New Jersey 08822-2900

SPECIFIC SERVICE(S) BEING REQUESTED:
☐ Transportation (LINK) RETURN THIS FORM

NOTE: IF YOU APPLYING FOR TRANSPORTATION, COMPLETE TOP BLOCK ON OTHER SIDE OF FORM.

PLEASE COMPLETE FULLY; USE N/A FOR ANY ITEMS NOT APPLICABLE

PLEASE PRINT: DATE OF BIRTH

LAST NAME FIRST NAME MIDDLE INITIAL MONTH DAY YEAR

ADDRESS:

TELEPHONE #

ARE YOU DISABLED? ☐ YES ☐ NO

IF YES, DO YOU HAVE FAMILY/FRIEND TO ASSIST YOU? ☐ YES ☐ NO

NAME: PHONE:

FAMILY SIZE (TOTAL NUMBER OF FAMILY MEMBERS LIVING IN HOUSEHOLD)

	TOTAL HOUSEHOLD INCOME	PER MONTH
A.	TOTAL GROSS WAGES AND SALARIES	$
B.	NET INCOME FROM SELF-EMPLOYMENT AND/OR RENTALS	
C.	GROSS INCOME FROM INTEREST, DIVIDENDS, TRUSTS	
D.	GROSS INCOME FROM PENSIONS (INCLUDING VETERAN)	
E.	SOCIAL SECURITY PAYMENTS (☐ SSA; ☐ DISABILITY; ☐ SSI)	
F.	UNEMPLOYMENT AND/OR WORKERS COMPENSATION	
G.	TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	
H.	GENERAL ASSISTANCE (WHICH MUNICIPALITY?)	
I.	OTHER INCOME (As defined by INTERNAL REVENUE SERVICE-PLEASE LIST SOURCES AND AMOUNTS – e.g., Alimony, Child Support)	

*****MEDICAL COVERAGE*****

Are you a Medicaid Recipient:

☐ Yes ☐ No If Yes, Medicaid # -

HMO Provider (if applicable)

If No, Date Applied For:

Date Authorized by DSS:

Do you have other health insurance? ☐ Yes ☐ No If Yes, Name of Carrier:

ID#:

Group#:

I certify that all of the above information is accurate and correct as presented.

SIGNATURE OF APPLICANT: _____

DATE

OR,

AGENCY/REPRESENTATIVE: _____

DATE

☐ I accept. Please check this box in lieu of signature if you are submitting this form electronically indicating agreement to the above certification.

(over for service authorization)

FOR TRANSPORTATION REQUEST ONLY

TRIP PURPOSE (Check all that apply): **FREQUENCY** (Note how often required and circle whether per week or month)

☐ MEDICAL (Physical Health Care Related Only)	per week/month
☐ EMPLOYMENT	per week/month
☐ ANY SOCIAL SERVICES (e.g., Counseling;	per week/month
Day Hospital; Etc.)	per week/month
☐ RECREATION	per week/month
☐ SHOPPING	per week/month
☐ OTHER (Explain)	per week/month

FOR COUNTY USE ONLY ___ NOT APPROVED. DATE_____ INITIALS_____

1. APPROVED FOR:

					DATE	INITIALS
__ TANF	__TXX/SSBG	__REDUCED FARE	($_____)	__FULL FARE	_____	_____
__ POST.TANF	__COUNTY FEE	__REDUCED FEE	($_____)	__NO REDUCTION	_____	_____
__ 250% PLC __#, SESSIONS		__FEE/SESSION	($_____)		_____	_____

__HHA: __DSS/SSBG; __OOA/SSBG; __CO.CP; __TITLE III: __NO FEE

CARD #_____

SUBMIT FORM NOW: SUBMIT

OR MAIL TO:

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Consolidated Service/Income Eligibility
PO Box 2900
Flemington, NJ 08822-2900