

**New Jersey Department of Human Services  
Division of Developmental Disabilities  
Fiscal Information Form**

Name: \_\_\_\_\_

**I. Social Security Benefits**

A. Does the Applicant receive Social Security Administration Death or Disability benefits (SSA/SSDI)?

Yes  No

1. If yes, Claim # \_\_\_\_\_ and amount received per month \$ \_\_\_\_\_

Who is Representative Payee for the SSA/SSDI benefit?

Relationship	Name	Address	City/State/Zip	Telephone

2. If no,  Never Applied  Application Pending  Ineligible

B. Does the Applicant receive Supplemental Security Income benefits (SSI)?

Yes  No

1. If yes, Claim # \_\_\_\_\_ and amount received per month \$ \_\_\_\_\_

Who is Representative Payee for the SSI benefit?

Relationship	Name	Address	City/State/Zip	Telephone

2. If no,  Never Applied  Application Pending  Ineligible

**II. Other Benefits and Assets**

Please show other assets or sources of income such as Applicant's Salary, Bank Accounts, Trust Accounts, Stocks & Bonds, Malpractice Accounts, Veteran's Benefits, Railroad Retirement Income, Pensions, Alimony...  
But only if they are personally owned by the applicant or received in the applicants name.

Type of Benefit or Asset	Account Name	Address	City/State/Zip	Account or Claim Number	Current Balance or Amt Received Monthly
				#	\$
				#	\$
				#	\$

**III. Representative Payee**

Who is the Representative Payee for the listed financial information? Please fill in below:

Which Benefit or Asset	Relationship	Name	Address	City/State/Zip	Telephone

**IV. Family and Members of Household**

List name of all relatives that share the same home as the applicant:

Relationship	Name	Date of Birth	Relationship	Name	Date of Birth