

ATTENTION: If you need your copay reduced because of a change in your family circumstances, please submit this form within 10 DAYS of the change.

Today's Date:

CC-198 (Rev. 4/17)

____ / ____ / ____
Month Day Year

New Jersey Child Care Subsidy Program NOTIFICATION OF CHANGE FORM (C)

Instructions – Notify your Child Care Resource and Referral Agency (CCR&R) of any changes by completing and submitting this form to the address listed below.

Name of Applicant: _____ Address: _____ Name of Co-Applicant: _____ Family Identifier: _____	Please mail this form to: Child Care Resources 3301C Rt. 66 PO BOX 1234 Neptune, NJ 07754
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The Below Change Occurred on: _____ / _____ / _____ <div style="text-align: center; font-size: small;">Month Day Year</div>	<input type="checkbox"/> I Need a Copay Reassessment
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STATUS CHANGE

Termination of Employment/School/Training: _____
(Name of Employer, School/Training Site)

Medical Leave/Family Leave/Maternity Leave

Seasonal Work/ School Break

Reduced Hours/School/Training New Weekly Hours: _____ New School Credits (Total): _____

Wage Reduction or Increase New Wage Amount: _____ Weekly Bi-weekly Monthly Other _____

Policy Reminder – Families with income that exceeds 85% of State Median Income during the eligibility period will not be eligible for child care assistance.

The information in the chart below is based on the FY 2016 Annual Update of the Department of Health & Human Services Poverty Guidelines and FY 2016 Department of Justice Census Bureau data on Median Family Income by Family Size.

If Your Family Size is	⇒	1	2	3	4	5	6	7	8	9	10	11	12
Your Income Cannot Exceed	⇒	\$52,826	\$63,211	\$78,615	\$96,436	\$103,576	\$110,716	\$117,856	\$124,996	\$132,136	\$139,276	\$146,416	\$153,556

Note: If Your Family Size is more than 12, Each Additional= \$7,140

HOUSEHOLD SIZE CHANGE

New Birth or Adoption Eligible Dependent (Adult Over age 18) Marriage Divorce/Separation Death Other: _____

Household Size Change									
	Name	DOB	Sex	SSN		Add	Remove		
Child						<input type="checkbox"/>	<input type="checkbox"/>		
Child						<input type="checkbox"/>	<input type="checkbox"/>		
Co-Applicant						<input type="checkbox"/>	<input type="checkbox"/>		
Dependent						<input type="checkbox"/>	<input type="checkbox"/>		

This is to certify that I experienced the above change and wish to update my family status as indicated on this form.

- I understand that if I wish to have my co-pay reassessed due to a change in circumstance, I must submit my request within 10 days of the change.
- I understand that if I experience a change in my employment/school/training status that exceeds three months, I must immediately notify the Child Care Resource and Referral Agency listed above.
- I understand that DFD or its designee reserves the right to verify status changes during the eligibility period and that I may be required to provide documentation according to child care policy.
- I understand that I could face adverse action, which may include termination of child care services and payment recoupment if I misrepresent any information provided on this form.

Applicant Signature	Date
Co-Applicant Signature	Date

AGENCY USE ONLY:

CCR&R Authorizing Signature	Date
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