***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:**

_______ /________ / ________
Month Day Year

*CC-198 (Rev. 4/17)*

# 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**

**The Below Change Occurred on:** ____________________/ ____________________/ ______________________
Month Day Year

☐ **I Need a Copay Reassessment**

**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** | ⇒ | **$56,711** | **$68,257** | **$85,939** | **$104,103** | **$111,243** | **$118,383** | **$125,523** | **$132,663** | **$139,803** | **$146,943** | **$154,083** | **$161,223** |

**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 | | | | | ☐ | ☐ |
| Child | | | | | ☐ | ☐ |
| Co-Applicant | | | | | ☐ | ☐ |
| Dependent | | | | | ☐ | ☐ |

**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**