



NACCRRRA # \_\_\_\_\_

# Child Care and Early Education Service Eligibility Application

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:

Child Care Resources

PO Box 1234

Neptune NJ 07754-1234

## A Applicant/Co-Applicant Information Please Read Instructions, Print Clearly, Answer All Questions

**1. PARENT/APPLICANT NAME** SOCIAL SECURITY NO. DATE OF BIRTH

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)

The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.

RACE:  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White

ETHNICITY: Hispanic/Latino:  Yes  No SEX:  Male  Female

Relationship of APPLICANT to children:  Father  Mother  Legally Responsible Adult  Foster Parent  Other: \_\_\_\_\_

**2. PARENT/CO-APPLICANT NAME (If Applicable)** SOCIAL SECURITY NO. DATE OF BIRTH

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)

The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.

RACE:  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White

ETHNICITY: Hispanic/Latino:  Yes  No SEX:  Male  Female

**3. HOME ADDRESS (Number and Street)** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ School District: \_\_\_\_\_

**4. HOME TELEPHONE:** \_\_\_\_\_

**5. NUMBER OF ADULTS IN FAMILY:** \_\_\_\_\_ **NUMBER OF CHILDREN IN FAMILY:** \_\_\_\_\_ **TOTAL FAMILY SIZE:** \_\_\_\_\_

Family size includes parent, spouse, children for whom subsidy is requested, other dependent children, or adults claimed on applicant's or co-applicant's IRS 1040. In cases of kinship, family size includes the child for whom subsidy is requested and all dependents claimed on the grandparent's, aunt's or relative's IRS 1040. For DYFS cases, a child and any of his/her siblings living in the same home and who are in DYFS-paid out of home placement shall be counted to determine the size of the family.

## B Family Income Information Attach Original Proof of Income - Most Recent Four Consecutive Weeks

Information is not required for DYFS-paid caregivers. Payments for DYFS children in out of home placement does not count as income.

For each source, enter income information either by week, bi-weekly, month or year. Include child support and/or alimony.	PARENT/APPLICANT List gross income for current:				PARENT/CO-APPLICANT List gross income for current:			
	WEEK	2 WEEKS	MONTH	YEAR	WEEK	2 WEEKS	MONTH	YEAR
1. Wages and Salary (gross):								
2. Pensions, Retirement:								
3. Supplemental/Social Security Benefits:								
4. Unemployment, Workmen's Compensation:								
5. TANF Cash Assistance:								
6. Child Support/Alimony:								
7. Other: _____								
8. TOTAL GROSS INCOME:								

## C Work/School/Training Information Proof of Current School Registration Must Be Attached

	PARENT/APPLICANT	PARENT/CO-APPLICANT
Name of PRIMARY Work/School/Training Site: Complete Address (Street, City, State, & Zip.: (If applicable, enter "Self-Employed")		
Telephone Number: ( ) _____		
Check One: Enter Starting Date (Mo/Dy/Yr):	<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____	<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____
Check One and Enter: Number of Hours/Week and Months/Year for Work/School/Training	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr
Name of SECONDARY Work/School/Training Site: Complete Address (Street, City, State, & Zip.: Telephone Number: ( ) _____		
Check One: Enter Starting Date (Mo/Dy/Yr):	<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____	<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____
Check One and Enter: Number of Hours/Week and Months/Year for Work/School/Training	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr

\* Incomplete Applications Will Not Be Accepted \*

DHS/CC:1 (12/08)

**D** YES NO

**All Questions Must Be Answered. Incomplete Applications Will Not Be Accepted.  
Supporting Documents Must Be Attached For Verification**

- 1. Are you currently participating in the Food Stamp Program?
- 2. Are you currently receiving/have you received assistance for child care with a Temporary Assistance for Needy Families (TANF) or Transitional Child Care (TCC) grant through the Work First New Jersey (WFNJ) Program within the last two years? If yes, indicate when benefits do/did expire by entering Month, Day and Year \_\_\_\_/\_\_\_\_/\_\_\_\_ and TANF case number: \_\_\_\_\_
- 3. Is your family an active case with the Division of Youth and Family Services (DYFS) and are the children for whom you are requesting subsidy residing with you? If yes, please give the name of the office: \_\_\_\_\_
- 4. Are you currently receiving a TANF grant? If yes, please indicate the TANF case number: \_\_\_\_\_
- 5. Do you or a member of your family have a chronic medical problem for which child care is recommended as part of a treatment/rehabilitation plan? If yes, indicate the name of the individual/agency authorizing the treatment plan and telephone number:  
Agency Name: \_\_\_\_\_ Telephone #: ( ) \_\_\_\_\_
- 6. Are you the head of the household in which you reside?
- 7. Are you currently homeless or at risk of becoming homeless?
- 8. Are the children for whom you are requesting child care assistance in a DYFS foster home, DYFS para-foster home, or DYFS pre-adoptive home. **If you are employed or participating in a school or training program, proof must be attached for DYFS purposes.**
- 9. Do you receive any cash or voucher assistance to specifically pay for housing?
- 10. Are you requesting assistance because the County Welfare Agency/Board of Social Services (CWA/BSS) informed you that you are ineligible for the Temporary Assistance for Needy Families (TANF) or Transitional Child Care (TCC) Program?
- 11. I understand that I am applying to the agency for:  **VOUCHER** payment assistance  **CONTRACTED** services in a community-based center
- 12. Do all of the children in this family have health insurance benefits?  Yes  No  
If NO, do you wish to receive an application for NJ Family Care?  Yes  No

**E** Children Information

**Include Each Child Needing Child Care Service and for Whom Assistance Requested.  
Use Addendum Form to Provide Information for Additional Children.**

**FULL NAME OF CHILD NO. 1** SOCIAL SECURITY NO. DATE OF BIRTH  
 \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)  
*The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.*  
**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female  
 Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FULL NAME OF CHILD NO. 2** SOCIAL SECURITY NO. DATE OF BIRTH  
 \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)  
*The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.*  
**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female  
 Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FULL NAME OF CHILD NO. 3** SOCIAL SECURITY NO. DATE OF BIRTH  
 \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)  
*The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.*  
**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female  
 Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

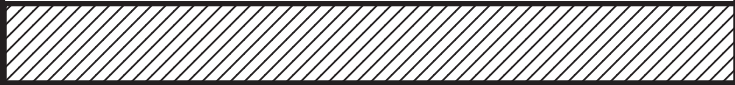
**You May Be Required to Provide Additional Proof of Family Size, Income, Citizenship or Residency to Verify Eligibility.  
Supporting Documentation Required May Include Most Current IRS Form 1040, Utility Bill or Birth Certificate.**



# Child Care and Early Education Service Eligibility Application

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:



Parent/Applicant Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Complete for Each Additional Child for Whom You Are Requesting Subsidy

**4** FULL NAME OF CHILD NO. 4 SOCIAL SECURITY NO. DATE OF BIRTH  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)

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**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female

Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**5** FULL NAME OF CHILD NO. 5 SOCIAL SECURITY NO. DATE OF BIRTH  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)

The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.  
**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female

Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**6** FULL NAME OF CHILD NO. 6 SOCIAL SECURITY NO. DATE OF BIRTH  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)

The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.  
**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female

Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**7** FULL NAME OF CHILD NO. 7 SOCIAL SECURITY NO. DATE OF BIRTH  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)

The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.  
**RACE:**  American Indian or Alaskan  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  
**ETHNICITY:** Hispanic/Latino:  Yes  No **SEX:**  Male  Female

Indicate the hour/days/duration for which child care is needed: \_\_\_\_\_  
 Child has a special need:  No  Yes **If yes, state special need and attach verification:** \_\_\_\_\_  
 Child is a US citizen or a qualified alien?  No  Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

**AGENCY USE:** Status (Check One):  Denied  Approved  Waiting List  Pending  
**DYFS USE:** (Enter the NJ Spirit Case No.) \_\_\_\_\_ Program: \_\_\_\_\_ Code: \_\_\_\_\_ Component: \_\_\_\_\_  
 Assessed Co-Payment (Enter and Circle One): \$ \_\_\_\_\_ Wk. \_\_\_\_\_ Mo. \_\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**Child Care and Early Education Service Eligibility Application Certification****READ CAREFULLY BEFORE SIGNING**

I (we) hereby certify that all of the information provided is true and correct to the best of my (our) knowledge. I (we) know that submitting false information about my (our) situation, failing to give the necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution. I (we) also understand that:

1. Acceptance of child care financial assistance is not for my (our) personal use or expenses and that federal, state and local public funds are and will be used as payment for costs that are directly associated with services rendered by a child care provider.
2. It is unlawful to obtain financial assistance for child care services by providing any false or misleading information, including but not limited to information about my eligibility and/or information that relates to child attendance for provider records, sign-in sheets or voucher payment forms. Examples of unlawful behavior include, but are not limited to:
  - Failing to accurately report all sources of my (our) income. Examples include, but are not limited to not reporting multiple sources of income, or an increase or decrease in wage/salary, child support payments, or alimony, or any other income.
  - Failing to accurately report the amount of my income. Examples include, but are not limited to reporting the accurate amount(s) of income from self-employment; rent from property ownership or changing or altering pay stub information.
  - Failing to accurately report the number of household members. Examples include, but are not limited to failing to report that my spouse or another parent/guardian is living in the household.
  - Pre-signing and dating voucher certification forms, sign-in sheets or other provider records used to track and verify child attendance.
  - Failing to accurately verify child attendance on voucher payment records/forms within the reporting timeframes.
3. This information is being given in connection with federal, state and local public funds and will be used through computer matching programs to confirm the accuracy of my (our) statements and verify my (our) income, resources and need for child care assistance, as warranted.
4. Providing the requested information, including the Social Security Numbers of Parent(s)/Applicant(s), is voluntary. Agency staff may use my (our) names and Social Security information with federal and state agencies and other sources deemed necessary for official examination. However, copies of birth certificates, social security and qualified alien resident cards, if applicable, are required for all children for whom subsidy services are being requested.
5. Failure to provide or deliberate misrepresentation of required information will result in the denial of my (our) application, termination of child care benefits to the family and referral to federal, state or local agencies for criminal or civil court action, garnishment of wages or tax intercept, as well as private claims collection agencies for claims action involving repayment and recovery of funds.
6. Providing false or misleading information in connection with my (our) application for child care financial assistance, and/or failing to report within ten days any change in my (our) family size or family income or any other circumstances that might change my (our) eligibility, such as work/school/training status, may result in the termination of my (our) child care subsidy and make me (us) ineligible to apply for and/or receive subsidized child care for a period of six months for the first violation; for a period of 12 months for a second violation; and permanent disqualification for the third violation.
7. If I receive financial assistance as a result of false or misleading information, I (we) may be responsible to repay the costs of child care and may be subject to a civil fine and possible criminal prosecution.
8. I (we) understand that in order to verify my (our) income and service need, an agency representative may need to contact my (our) employer(s). I (we) hereby authorize my (our) employer(s) to release information regarding my (our) income, pay scale, hours and schedule of work to the agency to which I am applying.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Unsigned applications cannot be processed. A copy of this document will be provided to you for your records.**

**DYFS USE ONLY**

DYFS Case Manager Name and Number: \_\_\_\_\_ Date: \_\_\_\_\_

Note: \_\_\_\_\_

SAR has been completed; voucher payments for DYFS/CPS child care services are approved for the period \_\_\_\_ / \_\_\_\_ / \_\_\_\_ thru \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DYFS Voucher Payment Authorization Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CCR&R or CENTER-BASED CONTRACTED (CBC) PROVIDER USE ONLY:**

Check One:  Initial Application     Re-determination    Certification Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Family Size: \_\_\_\_\_ Annual Family Income: \$ \_\_\_\_\_

Family's Total Assessed Co-Payment, if applicable (Enter Amt. and Check One): \$ \_\_\_\_\_  WEEK     MONTH

Check One:  DENIED     APPROVED     PENDING

Staff Member Certification: \_\_\_\_\_ Date: \_\_\_\_\_

Note: \_\_\_\_\_

Name of CCR&R or CBC Provider: \_\_\_\_\_