

New Jersey Cares for Kids

Child Care Subsidy Program

Questions?

Call 1-800-734-4810

- Attached is your Eligibility Application for the New Jersey Cares for Kids Child Care Subsidy Program. New Jersey Cares for Kids helps working families meet the cost of child care.
- **The eligibility requirements of the NJCK Program are as follows:**
 - ✓ Must be a Monmouth County resident
 - ✓ Must be employed full time (at least 30 hours per week) OR
 - ✓ Attend school full time (at least 20 hours per week) OR
 - ✓ Work part time AND go to school/training part time
 - ✓ Must meet income eligibility guidelines.
- If you need help finding child care, please contact your Subsidy Case Manager
- Once you are receiving child care subsidy any changes must be reported within 10 days to your Subsidy Case Manager.

INCOMPLETE OR FAXED APPLICATIONS WILL NOT BE ACCEPTED

BE SURE TO INCLUDE THE FOLLOWING:

- A month's worth of paystubs OR school/training registration
- Documentation of additional income, including child support, SSI, additional employment, unemployment, disability benefits, etc.
- Copy of each child's birth certificate and social security card in household.
- Proof of Food Stamps and Housing Assistance, if you receive it.
- If you receive child support submit proof of child support payments through Probation. If you have a personal mutual agreement submit a letter from the father/mother stating the details of payment arrangements.
If you are self-employed please include a copy of Schedule C and the tax transcript from the most recent tax return. This is through the IRS
- Do not forget to include Co-Applicant (Co-Applicant must meet same eligibility)
- Mail in proof of residency-Copy of your license, utility bill, or lease.

PLEASE PRINT CLEARLY

INCOME ELIGIBILITY GUIDELINES

GROSS ANNUAL INCOME FOR HOUSEHOLD CANNOT EXCEED:

Family Size of 2: \$34,840
Family Size of 3: \$43,920
Family Size of 4: \$53,000
Family Size of 5: \$62,080
Family Size of 6: \$71,160
Family Size of 7: \$80,240



NACCRA # _____

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.

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:**
PARENT/APPLICANT
List gross income for current:

WEEK	2 WEEKS	MONTH	YEAR

PARENT/CO-APPLICANT
List gross income for current:

WEEK	2 WEEKS	MONTH	YEAR

C**Work/School/Training Information****Proof of Current School Registration Must Be Attached**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):☐ Work ☐ School ☐ Training

Start Date ____/____/____

Check One and Enter: Number of Hours/Week and Months/Year for Work/School/Training☐ Full Time ☐ Part Time _____ # Hrs/Wk☐ Seasonal Employment _____ # Mos/YrName of **SECONDARY** Work/School/Training Site:

Complete Address (Street, City, State, & Zip.:

Telephone Number: () _____

Check One: Enter Starting Date (Mo/Dy/Yr):☐ Work ☐ School ☐ Training

Start Date ____/____/____

Check One and Enter: Number of Hours/Week and Months/Year for Work/School/Training☐ Full Time ☐ Part Time _____ # Hrs/Wk☐ Seasonal Employment _____ # Mos/Yr**PARENT/CO-APPLICANT**☐ Work ☐ School ☐ Training

Start Date ____/____/____

☐ Full Time ☐ Part Time _____ # Hrs/Wk☐ Seasonal Employment _____ # Mos/Yr☐ Work ☐ School ☐ Training

Start Date ____/____/____

☐ Full Time ☐ Part Time _____ # Hrs/Wk☐ 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.) _____		
	<i>The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.</i>		
	RACE: <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White		
	ETHNICITY: Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Indicate the hour/days/duration for which child care is needed: _____		
	Child has a special need: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, state special need and attach verification: _____		
	Child is a US citizen or a qualified alien? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)		
	AGENCY USE: Status (Check One): <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Waiting List <input type="checkbox"/> 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.) _____		
	<i>The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.</i>		
	RACE: <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White		
	ETHNICITY: Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Indicate the hour/days/duration for which child care is needed: _____		
	Child has a special need: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, state special need and attach verification: _____		
	Child is a US citizen or a qualified alien? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)		
	AGENCY USE: Status (Check One): <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Waiting List <input type="checkbox"/> 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.) _____		
	<i>The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.</i>		
	RACE: <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White		
	ETHNICITY: Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Indicate the hour/days/duration for which child care is needed: _____		
	Child has a special need: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, state special need and attach verification: _____		
	Child is a US citizen or a qualified alien? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)		
	AGENCY USE: Status (Check One): <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Waiting List <input type="checkbox"/> 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.) _____		
	<i>The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.</i>		
	RACE: <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White		
	ETHNICITY: Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Indicate the hour/days/duration for which child care is needed: _____		
	Child has a special need: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, state special need and attach verification: _____		
	Child is a US citizen or a qualified alien? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)		
	AGENCY USE: Status (Check One): <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Waiting List <input type="checkbox"/> 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: _____



At Child Care Resources we are committed to helping children and families thrive by providing child care financial assistance for eligible families, informing parents of available child care options and connecting them to community resources to support the healthy development of the entire family. Please take a moment and complete this short questionnaire so that we may better help you and offer more personalized service (any information you share will be kept strictly confidential). Thank you.

Name. _____

E-mail Address. _____

Basic Needs.

1. Is your child currently wearing diapers? ☐ Yes ☐ No

IF YES

- Are you currently receiving diaper donations from any other agencies? ☐ Yes ☐ No
- What size diaper is your child wearing? _____
- Would you like us to refer your information to a local diaper bank to see if you are eligible to receive diaper donations? ☐ Yes ☐ No

2. Are you having trouble with Housing Expenses? ☐ Yes ☐ No

IF YES:

- Electric Bill? ☐ Yes ☐ No
- Heating Bill? ☐ Yes ☐ No
- Housing/Rent? ☐ Yes ☐ No
- Other? ☐ Yes ☐ No If yes, explain: _____

3. Do you feel you are able to meet basic nutritional needs for your child and/or family? ☐ Yes ☐ No

IF NO:

- Are you familiar with the WIC (Women, Infants, and Children) Program? ☐ Yes ☐ No
- Do you need referrals to local food banks or pantries? ☐ Yes ☐ No
- Are you familiar with SNAP/MCDSS? ☐ Yes ☐ No

Health Insurance and Other Related Services.

1. Are you a recipient of NJ Family Care or other state subsidized health care plans? ☐ Yes ☐ No

- If no, would you like more information on NJ Family Care? ☐ Yes ☐ No

2. Is your child meeting or on target for meeting basic developmental milestones? Crawling, walking and talking when they should be? ☐ Yes ☐ No ☐ Unsure

3. Would you like to be referred for a Free Developmental Screening (ASQ) to assess your child's possible strengths and challenges? ☐ Yes ☐ No

4. Do you/your child have a disability or special need that you need referrals for support? ☐ Yes ☐ No

5. Do you need referrals for mental health services? ☐ Yes ☐ No

6. Would you like referrals for post-partum support? ☐ Yes ☐ No

Other:

1. Are you dealing with issues (housing, monetary, stress or coping) related to COVID-19? ☐ Yes ☐ No

2. Would you like Remote Learning Resources for your children? ☐ Yes ☐ No

3. Do you need Working from Home Resources for yourself? ☐ Yes ☐ No

4. Do you need grief resources to cope with the loss of a loved one? ☐ Yes ☐ No

5. Would you like referrals for:

Clothing? ☐ Yes ☐ No

Coats? ☐ Yes ☐ No

Toy drives? ☐ Yes ☐ No

Legal Aid? ☐ Yes ☐ No

If you need additional community referrals, please indicate below what types of referrals you require.

For Official Use Only.

Community Referrals Provided (write down number):

_____ Diaper Bank

_____ COVID-19

_____ Legal Aid Services

_____ Utility Assistance

_____ Health Insurance

_____ Early Intervention

_____ Housing/Rental Assistance

_____ Mental/Emotional Health

_____ Developmental Screening

_____ WIC

_____ Post-Partum Support

_____ Homelessness Prevention

_____ Food Bank/Pantries

_____ DCP&P Abuse/Neglect

_____ MCDSS General

_____ Clothing

_____ Disability/Special Needs

_____ SPAN

_____ Coats

_____ Advocacy

_____ SNAP - MCDSS

_____ Toys

_____ Remote Learning (kids)

_____ Remote Working

_____ School Supplies

_____ FSC

_____ Other (please describe): _____

NW#: _____

Total number of referrals given: _____

Program: _____

Staff Initials: _____

Date: _____



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF FAMILY DEVELOPMENT

NJ CHILD CARE SUBSIDY PROGRAM

Application Addendum

All families receiving a subsidy through the NJ Child Care Subsidy Program must provide the following information:

Are your family assets worth more than \$1,000,000? ☐ No ☐ Yes

Note: Assets may include but are not limited to, personal bank accounts, business accounts, real estate, and personal property.

If the primary language spoken in your home is **not** English, please specify that language: _____

Is the Applicant:

On Full-Time Active Military Duty ☐ No ☐ Yes

In the National Guard/Military Reserve ☐ No ☐ Yes

Self-Employed ☐ No ☐ Yes

Is there a Co-Applicant? ☐ No ☐ Yes

If yes, are they:

On Full-Time Active Military Duty ☐ No ☐ Yes

In the National Guard/Military Reserve ☐ No ☐ Yes

Self-Employed ☐ No ☐ Yes

Are you homeless based on one or more of the following? ☐ No ☐ Yes

- Living in an emergency or transitional shelter.
- Staying in a motel, hotel, trailer park, or campground or sharing housing with other persons due to loss of housing, economic hardship, or similar reason.
- Living in a car, bus/train station, park, abandoned building.
- Living or sleeping in any public or private place that is not normally used as a residence or as a regular sleeping accommodation.
- Living in substandard housing (i.e. no electricity, running water, etc.).

I hereby certify that all of the information provided is true and correct to the best of my knowledge. I also acknowledge that submitting false or misleading information, intentionally omitting information or intentionally causing others to omit or fail to report information is cause for denial or termination from the child care program and I may be subject to all legal and equitable remedies.

Applicant Name

Applicant Signature

Date

Co-Applicant Name

Co-Applicant Signature

Date

DISCRIMINATION

This program prohibits discrimination in determining eligibility for child care assistance.

If you believe you have been discriminated against by the New Jersey Child Care Subsidy Program because of race, color, disability, religion, national origin or another reason, you can contact:
Office of the Director, Division of Family Development, N.J. Department of Human Services, P.O. Box 716, Trenton, New Jersey 08625

PAGE INTENIONALLY LEFT BLANK

Parent/Applicant Name:

Family ID #:

NACCRRAware #:

CHILD'S ANNUAL CARE PLANS

Please complete an annual care plan for each child you are requesting a child care subsidy for.

CHILD'S NAME:

CHILD'S DATE OF BIRTH:

Please indicate the Applicant's employment or training hours for each day (ex: 9 am – 5 pm)

SUN	MON	TUES	WED	THURS	FRI	SAT

Please indicate the hours of child care your child will need each day (ex: 8:30 am – 5:30 pm)

SUN	MON	TUES	WED	THURS	FRI	SAT

Identify the dates that child care will be needed:

From: _____ (month/day/year) To: _____ (month/day/year)

Eligible Types of Child Care Providers

Please select the type of child care provider you are considering. If you have already selected a child care program, please complete the program's information in the space provided below.

Licensed Child Care Center	Before and After School- Age Care	Registered Family Child Care	Approved Home Provider	Summer Day Camp	Head Start	Dept. of Education Preschool

Child Care Program's Name, Address and Phone Number:

--

CHILD'S SUMMER CARE PLAN

*****COMPLETE THIS SECTION ONLY IF YOUR CHILD'S CARE WILL CHANGE FOR THE SUMMER*****

Please indicate the hours of child care your child will need each day (ex: 8:30 am – 5:30 pm)

SUN	MON	TUES	WED	THURS	FRI	SAT

Identify the dates that child care will be needed:

From: _____ (month/day/year) To: _____ (month/day/year)

Eligible Types of Child Care Providers

Please select the type of child care provider you are considering. If you have already selected a child care program, please complete the program's information in the space provided below.

Licensed Child Care Center	Before and After School- Age Care	Registered Family Child Care	Approved Home Provider	Summer Day Camp	Head Start	Dept. of Education Preschool

Child Care Program's **Name, Address and Phone Number:**

--

****PLEASE NOTE:** If your child requires care on ½ days and vacations during the school year, you will be responsible to pay for the additional cost of care. Remember to check the total cost of care for each of your children. If your provider's cost of care is more than the maximum allowable subsidy amount, you will be expected to pay the balance. This balance is called an **excess fee** and must be paid **in addition** to your copay. This Program is not responsible for any additional fees charged by the child care provider, including but not limited to transportation and activity fees.

Care Plans were completed:	***For Official Use Only***	
<input type="checkbox"/> In person with applicant(s)	Date: _____	
<input type="checkbox"/> By phone with applicant(s)	Date: _____	SCM Initials: _____

Parent/Applicant Name:

Family ID #:

NACCRRAware #:

CHILD'S ANNUAL CARE PLANS

Please complete an annual care plan for each child you are requesting a child care subsidy for.

CHILD'S NAME:

CHILD'S DATE OF BIRTH:

Please indicate the Applicant's employment or training hours for each day (ex: 9 am – 5 pm)

SUN	MON	TUES	WED	THURS	FRI	SAT

Please indicate the hours of child care your child will need each day (ex: 8:30 am – 5:30 pm)

SUN	MON	TUES	WED	THURS	FRI	SAT

Identify the dates that child care will be needed:

From: _____ (month/day/year) To: _____ (month/day/year)

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Care Plans were completed:	***For Official Use Only***
<input type="checkbox"/> In person with applicant(s)	Date: _____
<input type="checkbox"/> By phone with applicant(s)	Date: _____
	SCM Initials: _____

*****ACTION REQUIRED REGARDING YOUR CHILD CARE SUBSIDY*****

Dear Client,

Enclosed is the **Disqualification of Services for Parents** Policy issued by the State of NJ, Division of Family Development. This policy is effective immediately. Please read it carefully, sign below and return for your file. **This is due immediately.**

This policy details the steps that will be taken to suspend child care services for clients for the following reasons: failure to use ECC properly, failure to report all sources of income, failure to accurately report income, failure to report within 10 days any changes of house hold circumstances that change eligibility, etc. Violations for such penalties range from loss of child care services from one month to termination for one year.

It is important for our clients to know this policy as we will be enforcing it. Again, please read it carefully. If you have questions, please contact us.

Sincerely,

Kim Telesca, ext. 111
Subsidy Programs Manager
ktelesca@ccrnj.org

Sign Below and Return in the enclosed envelope. Due Upon Receipt.

****Please Print Clearly. ****

I am in receipt of the Child Care Policy Regarding Disqualification of Services of Parents.

Print Client Name: _____ Family ID/Case #: _____

Signature of Client : _____ Date: _____

Signature of Co-Applicant: _____ Date: _____

Email: _____ Phone #: _____



State of New Jersey

Department of Human Services
Division of Family Development
PO BOX 716
Trenton, NJ 08625-0716

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

JEANETTE PAGE-HAWKINS
Director
TEL: (609) 588-2000

July 7, 2014

**TO: CHILD CARE RESOURCE AND REFERRAL (CCR&R) DIRECTORS
COUNTY WELFARE AGENCY DIRECTORS**

**SUBJECT: CHILD CARE POLICY REGARDING DISQUALIFICATION OF SERVICES
FOR PARENTS**

DFD Instruction No. 14-07-01

Rescission of: DFDI 12-10-04 and 14-06-03

**Regulatory References: N.J.A.C. 10:15-6.14; N.J.A.C. 10:15-6.15; N.J.A.C. 10:15-9;
N.J.A.C. 10:15-10.4**

This instruction will impact all DFD Child Care Programs.

PURPOSE

To provide guidance and clarification to the CCR&Rs regarding the disqualification of child care services for parents.

BACKGROUND

Parents/applicants are required, at all times, to comply with New Jersey's subsidized child care program regulations and policies.

Any type of program violation will subject a parent/applicant to penalties that may include disqualification, termination, denial at time of application or reapplication, criminal investigation and/or recoupment of payment, if the parent/applicant is found by the CCR&R or DHS/DFD to be in violation of New Jersey's subsidized child care program regulations and policies.

DISQUALIFICATION PROCESS

A case of program violation can be brought to the Department of Human Services, Division of Family Development's (DFD) and/or CCR&R's attention through a variety of means, such as a phone call, letter, e-mail, newspaper article, television news broadcast, personal knowledge, or state databases used during the normal applicant eligibility determination and redetermination process. The CCR&R will then conduct an investigation to determine whether or not the program violation is substantiated. The CCR&R shall seek DFD guidance on cases in which clarification is required.

A substantiated case of program violation will result in the suspension or disqualification of child care subsidy and make the parent/applicant ineligible to apply/reapply for and/or receive subsidized child care for a specified period of time depending upon the number and type of violations.

A parent or applicant may appeal the decision to suspend or terminate the child care subsidy.

The steps to take to suspend or disqualify a parent/applicant child care subsidy for various violations are outlined below.

General Program Violations

Program violations that may result in suspension or disqualification include but are not limited to the following:

- (1) Failure to report within ten (10) calendar days any change in family size/composition, family income or any other **circumstances that change eligibility**, such as work/school/training status or income that exceeds program specific Federal Poverty Level (FPL) requirements, etc.
- (2) Failure to accurately report all sources of income. Examples include, but are not limited to, not reporting multiple sources of income (multiple employers), or an increase or decrease in wage/salary, child support payments, or alimony, unemployment, workman's compensation, pension, supplemental security income (SSI), social security disability income (SSDI), survivor benefits or any other income.
- (3) Failure to accurately report the amount of income. Examples include, but are not limited to, not reporting the accurate amount(s) of income from self-employment, rent from property ownership, or changing or altering pay stub information.
- (4) Failure to accurately report the number of household members who are required to be counted to determine family or household composition. Examples include, but are not limited to, failing to report that a spouse or another parent/guardian is living in the household.

ECC – Program Violation

Failure to comply with the E-Child Care Parent/Provider Responsibilities and Agreement may result in a warning notice, suspension or disqualification.

PENALTIES/PROCEDURES

Warning Notice

Upon evidence of an E-Child Care program violation, the CCR&R has seven (7) calendar days to send a warning letter (see attached) to the parents and offer training. CCR&Rs are required to provide written notification of parental warning to providers. For WFNJ cases, copies of all notices must also be sent to the County Welfare Agency (CWA). The parent/applicant will have up to two weeks (14 days) from the date of the warning letter to attend training and remedy the action by demonstrating consistent use of ECC. To document compliance or noncompliance, the CCR&Rs must print out the transaction report for that two-week period once the 14-day back swipe period has closed.

General Program and ECC Violations Penalties

Warning Notice

Upon evidence and/or notification of a program violation, the CCR&R has seven (7) calendar days to send a warning letter (see attached) to the parents/guardians. CCR&Rs are responsible for taking the necessary action to determine if the parent/guardian remains eligible and if repayment of funds is required.

First Violation (except fraud) – One (1) month disqualification

Upon completion of the one month disqualification, if the case is eligible, redetermination rules will apply. The eligibility threshold is 250% of the Federal Poverty Level (FPL) or below (350%-500% FPL for Kinship). WFNJ cases will require written notice to the CWA and verification that the CWA was informed of the disqualification.

Second Violation (except fraud) –Three (3) months disqualification

Upon completion of the three month disqualification, if the case is eligible, redetermination rules will apply. The redetermination eligibility threshold is 250% FPL or below (350%-500% FPL for Kinship). WFNJ cases will require written notice to the CWA and verification that the CWA was informed of the disqualification.

Third Violation and/or Fraud – Termination for up to twelve (12) months and/or permanent disqualification

If the violation has not resulted in permanent disqualification, parent could be subject to up to a twelve (12) month termination, after which the parent/applicant must reapply with the eligibility threshold being at 200% FPL or below.

Fraud or program violations that may be subject to up to a twelve (12) month termination include the following:

- (1) Failure to provide, or provision of, false or misleading or deliberate misrepresentation of, required information in connection with a new application or current child care subsidy case. (This may also result in the denial of any subsidy, 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.)
- (2) Reporting child(ren) present in attendance when child(ren) were not in attendance.
- (3) Repeated misuse of the ECC card resulting in multiple violations.
- (4) Repeated general program violation resulting in multiple violations.

WFNJ cases will require written notice to the CWA and verification that the CWA was informed of the termination for up to twelve (12) months.

Appeal Procedures:

It is the right of every parent who receives a disqualification notice from the CCR&R to request a review of his/her case by the CCR&R and/or DFD. The CCR&R must inform the parent of his/her right to request a review. A timely request must be made within ten (10) days of the date of the disqualification notice. See attached information on appeal rights.

FISCAL

The CCR&R must establish a Child Care Services Repayment Agreement with the parent, if it is discovered that an overpayment occurred as a result of a program violation or fraud. The CCR&R must maintain a copy of the Child Care Services Repayment Agreement in the family case record.

The CCR&R will collect and deposit in a bank all collections for overpayments received from the parent during the month. At the end of the month the CCR&R will write one check for the collections received during the prior month from the clients. The check should be made payable to "Treasurer State of New Jersey" and mailed to the Division of Family Development, Attention: Robert Hughes, Financial Reporting Unit. The CCR&R will also send a detailed report along with the check identifying the client, the amount, and the specific contract component (funding stream) for which the reimbursement applies. See attached report template.

TRAINING

DFD will continuously meet with the CCR&Rs and their policy staff to ensure that this policy is clear and understood.

OUTREACH AND NOTIFICATION

CCR&Rs are required to inform families in writing of this policy. CCR&Rs are required to ensure families have received written notification. Written verification must be placed

in the case file prior to taking any adverse actions. WFNJ cases require written notification and verification that the CWA was informed prior to any adverse action.

REPORTING

The CCR&R shall monitor and track all parents/applicants who have had their child care subsidies either suspended or terminated as result of program violation, and submit quarterly reports to the Child Care Specialist and report designee.

Sincerely,

SIGNED

Jeanette Page-Hawkins
Director

Attachments:

Child Care Services Repayment Agreement ECC-155(Rev06/14)
Warning Letter for Failure to Use or Misuse of ECC-161(New06/14)
Parent Disqualification Notice CC-171(Rev06/14)
Parent Repayment Fiscal Tracker CC-181(New06/14)
Warning Letter for Failure to Comply with Child Care Subsidy
Program Policy ECC-184(New07/14)

JPH:MM

Cc: Dr. Allison Blake, Commissioner
Department of Children and Families

Lisa Von Pier, Assistant Commissioner
Department of Children and Families

Valerie J. Harr, Director
Division of Medical Assistance and Health Services

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: _____	Please mail this form to: Child Care Resources 3301C Rt. 66 PO BOX 1234 Neptune, NJ 07754
Name of Co-Applciant: _____	
Family Identifier: _____	

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	⇒	58,194	69,912	89,039	109,645	117,295	124,945	132,595	140,245	147,895	155,545	163,195	170,845

Note: If Your Family Size is more than 12, Each Additional= \$7,650

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 _____