

Notification of Change Form

In November 2014, Congress reauthorized the Child Care Development Block Grant (CCDBG) Act. Changes in family circumstances have historically impacted eligibility, such as medical leave or termination of employment, training or school. The law now prevents certain changes in family circumstances from impacting eligibility.

The Notification of Change Form attached to this document is for you to keep in the event you have a change in family circumstances that may affect your eligibility. Changes that need to be reported include but are not limited to the following:

- Termination of Employment/School/ Training
- Medical Leave/Family Leave/Maternity Leave
- Seasonal Work/School Break
- Reduced Hours: Work/School/Training
- Wage reduction/increase
- Change in Family Size

Please note if you have a change that may affect your eligibility you must report the change within 10 business days. This form will make it easier to report the change as it outlines all of the changes that may occur within a 12 month eligibility period. It will allow our staff to determine if your change is covered under this new law so we can make all applicable changes to your agreement. If you do not report the changes you may be subject to a repayment agreement and/or termination of services.

If you have any questions about this policy or any of our other policies please contact our Subsidy Programs Manager, Kim Telesca at ext. 111 or your Subsidy Case Manager.

THIS FORM DOES NOT HAVE TO BE RETURNED WITH THIS PACKET,
PLEASE KEEP THIS DOCUMENT FOR FUTURE USE!!

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-Applicant: _____	
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 2024 Annual Update of the Department of Health & Human Services Poverty Guidelines and FY 2024 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	⇒	71,313	84,198	104,159	132,184	140,599	149,014	157,429	165,844	174,259	182,674	191,089	199,504

Note: If Your Family Size is more than 12, Each Additional= \$8,415

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