



CHILD CARE AND EARLY EDUCATION SERVICE ELIGIBILITY APPLICATION

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:
Programs for Parents, Inc.
 33 Washington Street, 6th Floor
 Newark, NJ 07102

A APPLICANT/CO-APPLICANT INFORMATION PLEASE READ INSTRUCTIONS, PRINT CLEARLY, ANSWER ALL QUESTIONS

1. PARENT/APPLICANT NAME SOCIAL SECURITY # 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 # 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 (# 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 4 CONSECUTIVE WEEKS

For each source, enter income information either by week, bi-weekly, month or year. Include child support and/or alimony.

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

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

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 to the Needy (TANF) or Transitional Child Care (TCC) Program?
- (Check One) 11. I understand that I am applying to the agency for: VOUCHER payment assistance CONTRACTED services in a community-based center

E INFORMATION ON CHILDREN INCLUDE EACH CHILD NEEDING CHILD CARE SERVICES AND FOR WHOM ASSISTANCE IS REQUESTED. USE ADDENDUM FORM TO PROVIDE INFORMATION FOR ADDITIONAL CHILDREN.

FULL Name of CHILD #1: _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____
 _____ (Last) _____ (First) _____ (M.I.) _____ (9 Digit Number) _____ (Mo./Dy./Yr.)

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for CHILD #1.

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:* _____

Name of center or caregiver if child is currently enrolled (To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.) _____

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending

DYFS USE: (Enter 8-digit Case #) KC _____/_____
 Program: _____ Code: _____ Component: _____ Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo. Enrollment Date: _____/_____/_____

FULL Name of CHILD #2: _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____
 _____ (Last) _____ (First) _____ (M.I.) _____ (9 Digit Number) _____ (Mo./Dy./Yr.)

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for CHILD #2.

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:* _____

Name of center or caregiver if child is currently enrolled (To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.) _____

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending

DYFS USE: (Enter 8-digit Case #) KC _____/_____
 Program: _____ Code: _____ Component: _____ Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo. Enrollment Date: _____/_____/_____

F CERTIFICATION I HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN IN CONNECTION WITH FEDERAL, STATE AND LOCAL PUBLIC FUNDS, THAT AGENCY OFFICIALS MAY VERIFY INFORMATION AND THAT DELIBERATE MISREPRESENTATION WILL RESULT IN THE DENIAL OF MY APPLICATION.

Signature of the Parent/Applicant: _____ Date: _____/_____/_____
Signature of the Parent/Co-Applicant: _____ Date: _____/_____/_____

G DYFS USE ONLY DYFS Case Manager Name & Number: _____ (Enter DYFS Case # in SECTION E)
 Check One (Applicable for children residing in their own home with birth parent): Reduce Co-Payment Waive Co-Payment

Additional Comments: _____

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

DYFS Voucher Payment Authorization Signature: _____ Date: _____/_____/_____
 DYFS Cost Code Number: _____

H AGENCY USE ONLY Check One: Initial Application Re-determination Enter Certification Date: _____/_____/_____
 Family Size: _____ Annual Family Income: \$ _____ Family's Total Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo.
 Certified by: _____ Agency: _____ Date: _____/_____/_____

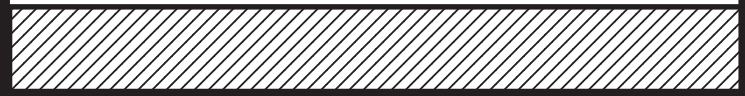
YOU MAY BE REQUIRED TO PROVIDE ADDITIONAL PROOF OF FAMILY SIZE, INCOME OR RESIDENCY TO VERIFY ELIGIBILITY. SUPPORTING DOCUMENTATION REQUIRED MAY INCLUDE MOST CURRENT IRS FORM 1040, UTILITY BILL OR BIRTH CERTIFICATE.



CHILD CARE AND EARLY EDUCATION SERVICE ELIGIBILITY APPLICATION ADDENDUM FORM

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

3

FULL Name of CHILD #3: _____ **SOCIAL SECURITY #** _____ **DATE OF BIRTH** _____

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

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #3**.

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:** _____

Name of center or caregiver if child is currently enrolled (To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.) _____

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending

DYFS USE: (Enter 8-digit Case #) KC _____/____

Program: ____ Code: ____ Component: ____ Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo. Enrollment Date: ____/____/____

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FULL Name of CHILD #4: _____ **SOCIAL SECURITY #** _____ **DATE OF BIRTH** _____

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

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #4**.

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:** _____

Name of center or caregiver if child is currently enrolled (To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.) _____

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending

DYFS USE: (Enter 8-digit Case #) KC _____/____

Program: ____ Code: ____ Component: ____ Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo. Enrollment Date: ____/____/____

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FULL Name of CHILD #5: _____ **SOCIAL SECURITY #** _____ **DATE OF BIRTH** _____

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

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #5**.

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:** _____

Name of center or caregiver if child is currently enrolled (To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.) _____

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending

DYFS USE: (Enter 8-digit Case #) KC _____/____

Program: ____ Code: ____ Component: ____ Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo. Enrollment Date: ____/____/____

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FULL Name of CHILD #6: _____ **SOCIAL SECURITY #** _____ **DATE OF BIRTH** _____

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

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #6**.

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:** _____

Name of center or caregiver if child is currently enrolled (To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.) _____

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending

DYFS USE: (Enter 8-digit Case #) KC _____/____

Program: ____ Code: ____ Component: ____ Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. Mo. Enrollment Date: ____/____/____

APPLICANT INSTRUCTIONS FOR COMPLETING THE CHILD CARE SERVICE ELIGIBILITY FORM

The following instructions are keyed to the various sections of this form. Please read carefully.

INSTRUCTIONS FOR COMPLETING SECTION A:

1. Enter your full name (last, first, middle initial), social security number and date of birth (month/date/year). Check one or more of the appropriate boxes provided to indicate your race. Check the appropriate box to indicate your ethnicity and sex. Check the appropriate box to indicate the relationship of the parent/applicant to the child(ren) for which you are making an application for assistance. If you are not an immediate relative (mother/father), please indicate whether you are another legally responsible person, a foster parent or other. If other, please specify.
2. If applicable (resides in household), enter the full name of your spouse or co-applicant, social security number and date of birth (month/date/year). Check the appropriate boxes provided to indicate the race, ethnicity and sex of the co-applicant/spouse.
3. Enter your home address and county in which you reside. Enter the school district which the child(ren) attends.
4. Enter your home telephone number.
5. Enter the "family size" meaning the number of adults (persons 18 years or older who are legally responsible for the children) and dependent adults (persons 18 years or older) who are in your immediate family unit, and the number of dependent children (persons under age 18).
Examples: In a single parent family with two children state: "# of Adults: 1, # of Children: 2."
In a two parent family with a dependent adult (grandparent) and two children state: "# of Adults: 3, # of Children: 2."
Note: If as a single parent, you and your child(ren) live with your mother and father, you would NOT include the grandparents in the family size.

INSTRUCTIONS FOR COMPLETING SECTION B:

PROVIDE INCOME INFORMATION BASED ON THE CURRENT YEAR. FILL IN ALL BLANKS. LIST GROSS FIGURES UNLESS OTHERWISE INDICATED. IF YOU RECEIVE NONE IN A CERTAIN CATEGORY, WRITE "0."

For each adult (applicant co-applicant or other dependent adult) residing in the household unit, list all current income information. Columns are provided to enter income information either by week, every two weeks, month or year. For separated or divorced spouses, include only that income (i.e., child support or alimony) which is available to the custodial family.

1. List all gross income due to wages and salary.
2. List all benefit income received from pensions and retirement.
3. List all benefit income received from Supplemental Security Income (SSI).
4. List all benefit income received from unemployment and workmen's compensation.
5. List all benefit income received from public assistance (TANF).
6. List income received from an absent parent for child support or alimony.
7. Include any other income received which is required to be listed for federal and state tax reporting purposes.
8. Indicate the annual total of all sources of income.

INSTRUCTIONS FOR COMPLETING SECTION C:

PROVIDE INFORMATION OF CURRENT WORK, SCHOOL AND/OR TRAINING ACTIVITY FOR APPLICANT AND CO-APPLICANT (if applicable).

1. Enter the name, complete address and telephone number of Primary Work/School/Training Site.
2. Check the appropriate box to indicate if activity is work, school or training.
3. Enter your starting date (month/date/year).
4. Check the appropriate box to indicate if Work/School/Training activity is full time, part time or seasonal. Enter the number of hours per week and months per year spent at site.
5. Include the information for your Secondary Work/School/Training activity (if applicable).

INSTRUCTIONS FOR COMPLETING SECTION D:

Questions 1-9. Check the appropriate box (either "Yes" or "No") for each question. If you answer "Yes" to any of questions 2-5, provide the requested information.

Questions 10. Check the appropriate box to indicate if you are applying for voucher payment assistance to reduce your child care costs or for contracted services in a community-based center.

INSTRUCTIONS FOR COMPLETING SECTION E:

- 1-2. Enter full name (last, first, middle initial), social security number and date of birth (month/date/year) for each child for whom assistance is requested. Check the appropriate boxes provided to indicate race, ethnicity and sex of child(ren). Indicate the hours, days and duration for which child care is needed. Check the appropriate box to indicate if the child(ren) has a special need, if yes, state the need. Enter the name of the center or caregiver if child(ren) is currently enrolled.

INSTRUCTIONS FOR COMPLETING SECTION F:

After reading the certification, applicant and co-applicant (if applicable) sign on the appropriate line and include the date.