



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 12, 2010

Dear Parent:

The Department of Human Services' (DHS) budget for State Fiscal 2011 includes new requirements for incoming families who need or want before/after school and/or summer child care services associated with the preschool program in school districts formerly known as Abbotts. These services are commonly called Wraparound Child Care and are provided by licensed, community based child care providers and school districts that provide:

- Four hours of part-time care before and/or after the six-hour program of preschool instruction for ten months (i.e., 180 days) that, at a minimum, meet the Department of Children and Families' (DCF) child care center licensing requirements; and
- Up to ten hours of program operation to enable children to receive full-time child care for six or more hours for two months (i.e., when schools are closed for the summer months during July and August).

As of September 1, 2010, to be determined eligible for the wraparound child care, parent/applicants must be employed full-time, in a full-time training or education program or a combination of the two to equal full time. In addition, family income must be at or below 200% of the 2009 Federal Poverty Level (FPL). If accepted, your family may remain eligible until your annual income exceeds 250% of the current Federal Poverty Level (FPL), and/or you no longer meet the new work/school and/or training eligibility requirement. If you do not meet the new eligibility criteria, you will be required to pay your child care provider directly for the full cost of the wraparound services at the prevailing price charged by that agency. In these cases, you must make payment to your provider directly prior to the service delivery period. The table below illustrates the income eligibility levels based on family size at 200% FPL:

FAMILY SIZE	2	3	4	5	6	7	8	9	10
MAXIMUM INCOME	\$29,140	\$36,620	\$44,100	\$51,580	\$59,060	\$66,540	\$74,020	\$81,500	\$88,980

If your income is below 100% of the FPL, wraparound child care services will still be free. However, you will need to submit proof of employment/education or training and income verification documents to be determined eligible. Applications and detailed information may be obtained by calling 1-800-332-9227 to speak to a representative of the Child Care Resource and Referral Agency (CCR&R) in your county.

To be determined eligible, families must:

- 1) Complete the Child Care Services Eligibility Application (DHS/CC:1 12/08) form and submit it to the local CCR&R;
- 2) Provide proof of employment and income (i.e. four most recent consecutive weeks pay stubs prior to the date of the application, letter from employer, W-2's, income tax returns etc.);
- 3) Provide verification of school or training;
- 4) Provide verification of unearned family income (i.e., TANF, SSI, child support, etc) and
- 5) Meet residency requirements established by the former Abbott school district where they reside

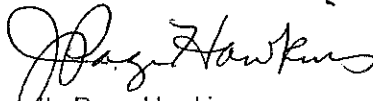
Eligible children must meet **age** (3 or 4 years of age) requirements established by the school district they will be attending.

Dear Parent
July 12, 2010
Page 2

If you are determined eligible for the wraparound child care subsidy, you will be assessed a small co-pay fee based upon your family size, income and hours of care. If your income is below 100% of the FPL, you will not be assessed a co-payment. A family of 3 with one child in wraparound child care and an annual income of \$27,465 will be required to pay \$50.83 per month for part-time care (less than 6 hours per day; September to June) and \$101.67 for full-time care (6 or more hours per day July and August).

DHS remains committed to providing services to support low-income families that need child care to work or attend school/training. For more information, contact the CCR&R in the county in which you reside at 800-332-9227.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeanette Page-Hawkins". The signature is fluid and cursive, with the first name "Jeanette" being the most prominent part.

Jeanette Page-Hawkins
Director

JPH:BW:hs



4CS OF PASSAIC COUNTY, INC.

Two Market Street, Paterson, NJ, 07501 * Phone (973) 684-1904 * Fax (973) 684-0468

Dear Parent / Guardian:

In order for your application to be processed without delay, please refer to the checklist below. Please check that **all items**, if applicable, are filled out and submitted. It is important that your application be **completed** or it cannot be accepted. Thank you.

_____ **APPLICATION/CO-APPLICANT**

_____ Social Security Number

_____ Date of birth

_____ **SUBMIT CURRENT W2 FORM OR 1040 FORM**

_____ **PROOF OF LEGAL GUARDIAN/CUSTODY**

_____ **EMPLOYMENT VERIFICATION**

_____ Last four (if paid wkly) or last two (if paid bi-wkly or semi-monthly) consecutive paystubs

_____ Letter/from employer stating hours work per week (typed on letter head)

_____ Indicate employer's address and/or telephone number

_____ **INCOME VERIFICATION**

_____ Proof of Unemployment, SSI, and/or Disability (last four weeks original stubs)

_____ Proof of AFDC (Letter from board of social services)

_____ Proof of Child Support (Stubs and/or letter)

_____ **PROOF OF SCHOOL**

_____ School Schedule (With school seal)

_____ **CHILD (REN)**

_____ Social Security Number – Copy of card must be submitted.

_____ Date of birth – Copy of birth certificate must be submitted

_____ Special needs (medical evaluation and/or letter from doctor)

_____ You stated that you have _____ children but only applied for _____ child(ren) need copy of child (ren) birth certificate(s)

_____ **SIGN SECTION F**

_____ Application and/or Co-Applicant

Thank you.

The Parent Services Department



Child Care and Early Education Service Eligibility Application

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:

The Child Care Resource and Referral Agency located in the county where you live. A list can be found at:
<http://www.state.nj.us/humanservices/dfd/programs/child/ccrr/>

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.

	PARENT/CO-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/CO-APPLICANT	PARENT/CO-APPLICANT
Name of PRIMARY Work/School/Training Site: Complete Address (Street, City, State, & Zip): <i>(If applicable, enter "Self-Employed")</i>		
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

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 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: _____



Child Care and Early Education Service Eligibility Application

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:

4CS of Passaic County, Inc.

2 Market Street 3rd Fl., Paterson, NJ 07501

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.)

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: ____/____/____

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: ____/____/____