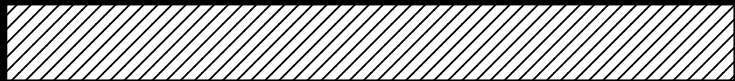




CHILD CARE AND EARLY EDUCATION SERVICE ELIGIBILITY APPLICATION

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:



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

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

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

	PARENT/APPLICANT List gross income for current:				PARENT/CO-APPLICANT List gross income for current:			
	WEEK	2 WEEKS	MONTH	YEAR	WEEK	2 WEEKS	MONTH	YEAR
1. Wages and Salary (gross):								
2. Pensions, Retirement:								
3. Supplemental/Social Security Benefits:								
4. Unemployment, Workmen's Compensation:								
5. TANF Cash Assistance:								
6. Child Support/Alimony:								
7. Other _____:								
8. TOTAL GROSS INCOME:								

C **WORK/SCHOOL/TRAINING INFORMATION** PROOF OF CURRENT SCHOOL REGISTRATION MUST BE ATTACHED

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

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: / /

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