Department of Human Services • Division of Family Development

New Jersey Child Care Assistance Program
Notification of Change Form

Instructions: Complete this form to report changes that affect your eligibility. You must report required changes (see section 1) within 10 calendar days of the change. Families with income that exceeds 85% of State Median Income (SMI) during the eligibility period, move out of New Jersey, or stop using child care will no longer receive Child Care Assistance Program payments. Completed forms must be submitted to your Child Care Resource and Referral (CCR&R) agency. To add a child or have your copayment reduced, you must include documentation to support current income and/or household size change (see Documentation Checklist in the CC-1).

CONTACT INFORMATION

Name of Applicant: _____ Name of Co-Applicant *(if applicable)*: _____

Phone Number: _____ Case ID: _____

SECTION 1 REQUIRED: Changes you MUST report

☐ My income exceeds 85% of SMI during the eligibility period (starting on _____)

Income Limits at 85% SMI

If your family size is	1	2	3	4	5	6	7	8
Income cannot exceed	$71,313	$84,198	$104,159	$132,184	$140,599	$149,014	$157,429	$165,844

These income limits are based on the 2024-2025 SMI. If family size is more than 8, each additional person = $8,415

☐ My child(ren) no longer needs child care (starting on _____)

☐ I moved out of New Jersey or to another county (residency change) (starting on _____)

New Address: _____ County: _____

☐ I changed providers (starting on _____)

New Provider Name: _____ Phone: _____

Provider Address: _____ County: _____

☐ I changed hours of care from full-time to part-time or part-time to full-time (new hours _____ starting on _____)

SECTION 2 VOLUNTARY: Changes you MAY report to add a child or request a copayment reduction

☐ Add new child to CCAP case

☐ Copayment change due to: ☐ Household size change (starting on _____) ☐ Income change (starting on _____)

Provide Current Wage Amount: $_____ ☐ weekly ☐ biweekly ☐ monthly (starting on _____)

☐ New Birth/Adoption ☐ Divorce/Separation ☐ Eligible Dependent *(adult over age 18)* ☐ Marriage ☐ Death

	Name	DOB	Sex	SSN	Add	Remove
Child					☐	☐
Child					☐	☐
Co-Applicant					☐	☐
Dependent					☐	☐

CERTIFICATION

This is to certify that I experienced the above change and wish to change my family status as indicated above. I understand that:

- I may be required to provide documentation according to program policies, and that the Division of Family Development or CCR&R reserves the right to verify status changes during the eligibility period.
- I could be subject to penalties, which may include disqualification from child care services and/or payment recoupment if I misrepresent any status changes.

_____ *Applicant Signature*

_____ *Co-Applicant Signature*

_____ *Date*

If you have questions or need help, contact your Child Care Resource and Referral (CCR&R) agency: