New Jersey Department of Human Services
Division of Family Development
Child Care Subsidy Program
McKinney-Vento Homeless Assistance Act Intake Form

Children of families that meet the McKinney-Vento Act definition for homelessness will be given a grace period up to six months to submit certain documentation that establishes program eligibility including proof of residence, income/employment records, and child birth/citizenship records.

☐ I am a Parent/Applicant ☐ I am a Service Provider Date: test

Child Name:	Child's Date of Birth:	Child's SSN: test

You must complete a separate copy of this form for all additional children.

Applicant Name:		Co-Applicant Name:	
Applicant Date of Birth:		Co-Applicant Date of Birth:	
Race: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	**Race:** ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

HOUSING/LIVING STATUS

Check the appropriate housing/living status for the above named child:

☐ Shelter
☐ Hotel/Motel/Campground
☐ Transitional Housing Program: _____ *Name of Program*
☐ Doubled up/Living at relatives' or friends' house
☐ Train, bus station, park or in a car
☐ Vacant apartment/building
☐ Other: test

☐ I have a mailing address (please add address below)	☐ I do not have a mailing address If you do not have a mailing address, would you like your e-Child Care/Families First Card to be mailed to the Child Care Resource and Referral Agency? ☐ Yes ☐ No

Check all that apply:

☐ I do not have a job/I am not in school or a job training program
☐ I work or go to school/training program part time. # of Credits: _____ # of Hours: _____
☐ I do not have my Child's Birth Records/Birth Certificate and/or Social Security Card

Parent/Applicant Certification

I understand that submitting this form will ensure that my application is accepted for review. I understand that within 45 days prior to the end of my grace period, I must submit the required documentation that was not provided at the time of application. I hereby certify that all of the information provided in this document is true and correct. I understand and know that submitting false or misleading information or failing to give the necessary information will result in termination and I will be subjected to recoupment of funding.

Parent/Applicant Signature: _____ Date: _____

Print Name: _____

Service Provider Certification

I have completed the information above to the best of my knowledge on behalf of the parent/applicant listed on this form. I hereby certify that the above named parent/applicant is receiving services under my organization/agency and the above named child meets the definition for homelessness under the McKinney-Vento Homeless Assistance Act (42 USC 11431 et seq), Title VII, Subtitle B, Section 725(2).

Service Provider Signature: _____ Date: _____

Print Name: _____ Title: _____

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF FAMILY DEVELOPMENT
OFFICE OF CHILD CARE

MCKINNEY-VENTO SERVICE PROVIDER REFERRAL & AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant Name:	Date of Birth:	
Co-Applicant Name:	Date of Birth:	
Use a copy of this form to provide information for additional children.		
Child Name:	Date of Birth:	SSN:
Child Name:	Date of Birth:	SSN:
Current Address:		

I, or my approved agent, ask that my information be shared only in the way this form describes.

I understand that:

1. If I place my initials on the line in item 8(b), I consent to the release of information listed in 8(a).
2. I have the right to cancel this authorization at any time by writing to the Service Provider listed below. I understand that I may cancel this authorization except to the extent that information has already been shared based on this approval.
3. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a child care program, or eligibility for benefits will not be conditioned upon my authorization of this release.
4. Information disclosed under this authorization will be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT ALLOW THE SERVICE PROVIDER OR ITS REPRESENTATIVES TO DISCUSS MY INFORMATION WITH ANYONE OTHER THAN THE CCR&R AGENCY SPECIFIED IN ITEM 7.**

6. Name and address of entity to release this information:

7. Name and address of person(s) to whom this information will be sent, discussed, and/or shared:

8 (a). Specific information to be released if available:

- ☐ Child(ren) Social Security Number(s)
- ☐ Child(ren) Age/Citizenship Documentation (i.e. Birth Certificate(s), Permanent Resident Card(s))
- ☐ Child(ren) Disability Documentation

(b). By initialing here_____, I authorize_____to discuss my family's information with the Child Care Resource and Referral (CCR&R) agency listed here:

9. Reason for release of information: ☐ At request of individual: ☐ Other:	10. Date or event on which this approval will expire: 12 months from date of signature or 90 days after termination
11. If not the applicant, name of person signing form:	12. Authority to sign on behalf of applicant: