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| **2022-2023 COVID-19 Family Differential Payment Acknowledgement Form**  **Policy**   * Effective January 2022, the Department of Human Services’ Division of Family Development shall provide COVID-19 Family Differential Payments to licensed child care centers and family child care providers on behalf of families participating in the Child Care Assistance Program. The increased amount ***must*** reduce or eliminate expenses in excess of the baseline State reimbursement payment, or apply as a credit (if monies are owed), towards tuition cost and other fees paid by the families. * Payments are up to $300 for full-time care, or $150 for part-time care, per eligible child, per month above the baseline reimbursement rates from **January 2022 through December 2023.** * Parents and providers participating in the Child Care Assistance Program are required to complete this form to acknowledge receipt of the payment policy change. | | | | | | | | |
| **PROVIDER INFORMATION** | | | | | | | | |
| **COUNTY:** |  | | | **NJCCIS ID:** |  | | | |
| **PROGRAM NAME:** |  | | | **DIRECTOR NAME:** |  | | | |
| **PHONE:** |  | | | **EMAIL:** |  | | | |
| **FAMILY INFORMATION** | | | | | | | | |
| **LAST NAME** |  | | | **FIRST NAME** | |  | | |
| **EMAIL** |  | | | **PHONE** | |  | | |
| **CHILDREN INFORMATION** | | | | | | | | |
| **Last Name** | | **First Name** | **Date of Birth** | | | | **Provider Weekly Rate** | **Provider Monthly Rate** |
|  | |  |  | | | |  |  |
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|  | |  |  | | | |  |  |
| I have read and understand the policy. I attest that the information provided above is accurate and complete to the best of my knowledge. I understand that this information is necessary to authorize timely COVID-19 Family Differential Payments in connection with the Child Care Assistance Program. | | | | | | | | |
| **Parent Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Director/Operator Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |

**Submit Forms within 30 days of receipt. Failure to return on time may result in payment delays.**

**Community Coordinated Child Care of Union County**

**Email**: [ccccforms@ccccunion.org](mailto:ccccforms@ccccunion.org)

**Phone: 973-923-1433**