



SUBSIDY FOR CHILD CARE IS AVAILABLE!!!

MUST MEET ONE OF THE FOLLOWING QUALIFICATIONS:

20 HRS. OF TRAINING PER WEEK
12 COLLEGE CREDITS PER SEMESTER
30 HRS. OF EMPLOYMENT PER WEEK
OR
PART-TIME EMPLOYMENT
&
PART-TIME SCHOOL
EQUIVALENT TO FULL-TIME

CHILDREN MUST BE US CITIZENS OR PERMANENT RESIDENTS

FAMILY SIZE	INCOME ELIGIBILITY
2	\$29,140
3	\$36,620
4	\$44,100
5	\$51,580
For each additional family member add	\$7,480

FOR MORE INFORMATION CONTACT:

4CS OF PASSAIC COUNTY, INC.
2 MARKET STREET, 3RD FLOOR
PATERSON, NJ 07501
973-684-1904





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.

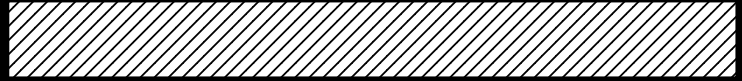
The Parent Services Department



CHILD CARE AND EARLY EDUCATION SERVICE ELIGIBILITY APPLICATION

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:



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.

	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: <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training		
Enter Starting Date (Mo/Dy/Yr): Start Date: ____/____/____		
Check One and Enter: <input type="checkbox"/> Full Time _____ # Hrs/Wk		
<input type="checkbox"/> Part Time _____ # Hrs/Wk		
<input type="checkbox"/> Seasonal Employment _____ # Mos/Yr		
Name of SECONDARY Work/School/Training Site: Street Address, City, State, & Zip.:		
Telephone Number: (____) _____ - _____		
Check One: <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training		
Enter Starting Date (Mo/Dy/Yr): Start Date: ____/____/____		
Check One and Enter: <input type="checkbox"/> Full Time _____ # Hrs/Wk		
<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?
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.



CHILD CARE AND EARLY EDUCATION SERVICE ELIGIBILITY APPLICATION CERTIFICATION – READ CAREFULLY BEFORE SIGNING

I (we) hereby certify that all of the above information is true and correct to the best of my (our) knowledge. I (we) know that lying 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 each household member, is voluntary. Agency staff may use my (our) name and Social Security information with federal and state agencies and other sources deemed necessary for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
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, a Child Care Resource and Referral Agency (CCR&R) 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 CCR&R in my (our) county of residence to whom I (we) apply for subsidized child care services in the State of New Jersey.

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 ADDENDUM FORM

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:

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 #4: _____ 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: ____/____/____

5 FULL Name of CHILD #5: _____ 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 #4.
 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: ____/____/____

6 FULL Name of CHILD #6: _____ 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 #5.
 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: ____/____/____

7 FULL Name of CHILD #7: _____ 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 #6.
 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: ____/____/____

APPLICANT INSTRUCTIONS FOR COMPLETING THE CHILD CARE SERVICE ELIGIBILITY FORM
(The following instructions are keyed to the various sections of this form. Please read carefully.)

INSTRUCTIONS FOR COMPLETING SECTION A:

1. Enter your full name (last, first, middle initial), social security number and date of birth (month/date/year). Check one or more of the appropriate boxes provided to indicate your race. Check the appropriate box to indicate your ethnicity and sex. Check the appropriate box to indicate the relationship of the parent/applicant to the child(ren) for which you are making an application for assistance. If you are not an immediate relative (mother/father), please indicate whether you are another legally responsible person, a foster parent or other. If other, please specify.
2. If applicable (resides in household), enter the full name of your spouse or co-applicant, social security number and date of birth (month/date/year). Check the appropriate boxes provided to indicate the race, ethnicity and sex of the co-applicant/spouse.
3. Enter your home address and county in which you reside. Enter the school district which the child(ren) attends.
4. Enter your home telephone number.
5. Enter the "family size" meaning the number of adults (persons 18 years or older who are legally responsible for the children) and dependent adults (persons 18 years or older) who are in your immediate family unit, and the number of dependent children (persons under age 18).

Examples: In a single parent family with two children state: "# of Adults: 1, # of Children: 2."

In a two parent family with a dependent adult (grandparent) and two children state: "# of Adults: 3, # of Children: 2."

Note: If as a single parent, you and your child(ren) live with your mother and father, you would NOT include the grandparents in the family size.

INSTRUCTIONS FOR COMPLETING SECTION B:

PROVIDE INCOME INFORMATION BASED ON THE CURRENT YEAR. FILL IN ALL BLANKS. LIST GROSS FIGURES UNLESS OTHERWISE INDICATED. IF YOU RECEIVE NONE IN A CERTAIN CATEGORY, WRITE "0."

For each adult (applicant co-applicant or other dependent adult) residing in the household unit, list all current income information. Columns are provided to enter income information either by week, every two weeks, month or year. For separated or divorced spouses, include only that income (i.e., child support or alimony) which is available to the custodial family.

1. List all gross income due to wages and salary.
2. List all benefit income received from pensions and retirement.
3. List all benefit income received from Supplemental Security Income (SSI).
4. List all benefit income received from unemployment and workmen's compensation.
5. List all benefit income received from public assistance (TANF).
6. List income received from an absent parent for child support or alimony.
7. Include any other income received which is required to be listed for federal and state tax reporting purposes.
8. Indicate the annual total of all sources of income.

INSTRUCTIONS FOR COMPLETING SECTION C:

PROVIDE INFORMATION OF CURRENT WORK, SCHOOL AND/OR TRAINING ACTIVITY FOR APPLICANT AND CO-APPLICANT (if applicable).

1. Enter the name, complete address and telephone number of Primary Work/School/Training Site.
2. Check the appropriate box to indicate if activity is work, school or training.
3. Enter your starting date (month/date/year).
4. Check the appropriate box to indicate if Work/School/Training activity is full time, part time or seasonal. Enter the number of hours per week and months per year spent at site.
5. Include the information for your Secondary Work/School/Training activity (if applicable).

INSTRUCTIONS FOR COMPLETING SECTION D:

Questions 1-9. Check the appropriate box (either "Yes" or "No") for each question. If you answer "Yes" to any of questions 2-5, provide the requested information.

Questions 10. Check the appropriate box to indicate if you are applying for voucher payment assistance to reduce your child care costs or for contracted services in a community-based center.

INSTRUCTIONS FOR COMPLETING SECTION E:

1-2. Enter full name (last, first, middle initial), social security number and date of birth (month/date/year) for each child for whom assistance is requested. Check the appropriate boxes provided to indicate race, ethnicity and sex of child(ren). Indicate the hours, days and duration for which child care is needed. Check the appropriate box to indicate if the child(ren) has a special need, if yes, state the need. Enter the name of the center or caregiver if child(ren) is currently enrolled.

INSTRUCTIONS FOR COMPLETING SECTION F:

After reading and understanding the certification, applicant and co-applicant (if applicable) sign on the appropriate line and include the date. A signed copy of the certification (SECTION F) must be attached to all applications, including initial and redetermination applications.