

State of New Jersey
Department of Human Services
Division of Family Development
 Child Care Subsidy Program

NEW JERSEY CHILD CARE SUBSIDY YOUTH CAMP REGISTRATION FORM

County:		Owner Name:	
Name of Camp:			
Camp ID#:		EPICC ID#:	
		OOL License #:	
Program Director Name:		Title:	
Site Address:		City/Town:	Zip Code:
Phone:	Fax:	Email:	
<input type="checkbox"/> Please check this box if your camp season is Summer only <input type="checkbox"/> Please check this box if you provide a camp program during School or Holiday Breaks <input type="checkbox"/> Please check this box if you operate another child care program during the School Year <input type="checkbox"/> Please check this box if you currently have an Office of Licensing (OOL) Child Care Center License for Summer 2018			
1. Is your camp located at a park? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. How many years have you operated a summer youth camp under the NJ Department of Health's Youth Camp Safety Act:			
3. Will you be applying for a new youth camp license or a renewal camp license for summer 2018? <input type="checkbox"/> New <input type="checkbox"/> Renewal			
4. Have you ever had a youth camp licensing application denied? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Have you had a youth camp license revoked within the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Have you reported any serious injuries or fatalities in 2016 and/or 2017 to the NJ Department of Health? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. If your program was in operation during the summer of 2017, did you submit to the NJ Department of Health, your program's CB15 Form by the required due date (September 2017)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Did you incur any penalties from the NJ Department of Health with the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Was your program cited for any violations by the public Board of Health within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Were you required to submit a corrective action plan within the last two years to either the NJ Department of Health or the local Health Department? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list all high risk activities as defined by N.J.A.C. 8:25 that you will be offering:			
Please check if you have written policies for the following:			
<input type="checkbox"/> Emergency/Disaster Policy & Procedures <input type="checkbox"/> Transportation Policies <input type="checkbox"/> Immunization Policies			
Please include with this application: <input type="checkbox"/> Copy of Liability Insurance <input type="checkbox"/> Copy of Current Fire Certificate			
<input type="checkbox"/> Letters of Approval or a Certificate of Occupancy issued by the appropriate local authority			