Glassboro Child Development Centers
Camp HORIZON & JURASSIC Summer Learning Program - 2024 Registration

Child's Name: ______________________________ Date of birth: ______________

Grade for 2023-2024 School Year: ________ Gender: M F **Shirt Size: Youth:** S M L XL

Parent's Name: ____ **Adult:** S M L XL

Address: ______________________ City ____________ State: _____ Zip: __________

Telephone: ______________________ Email: ______________________________

Does your child require any medication/special accommodations or have any allergies? _____Yes _____No
Does your child have an IEP/504 Plan? _____ Yes _____No
(If yes, must be received and accommodations in place before child begins)
Is there a court order (custody or restraining order) involving this child? _____Yes _____No
(If yes, we must have a copy, complete with judge/clerk's signature and date)

Registration Fees: $175 per child
Registration fees are non-refundable ______ *(initial here)*

Pricing:

Grade	21CCLC only (7am-11am)	In-District (11am-5:30pm 3rd-8th grade)	Out-of-District (7am-5:30pm)
1	n/a	*Full day* $160	$250
2	n/a	*Full day* $160	$250
3	Free	$80	$250
4	Free	$80	$250
5	Free	$80	$250
6	Free	$60	$195
7	Free	$60	$195
8	Free	$60	$195

*****Students attending the 21CCLC portion of the day only who are not picked up by 11am will be assessed a $16 fee due upon pick-up. Students <u>will not</u> be able to attend the next day without payment.*****

We accept NJCK Voucher/WFNJ
United in Care Tuition Assistance Available
There is no 2nd child discount.

- **MUST pay for the weeks registered whether they attend or not.**
- Breakfast & PM snack are provided daily.
- Must pack a totally disposable lunch.
- Registration fee and first week are due at time of enrollment.

All families are required to have an active ProCare account.

Fees are **automatically** deducted every week.

Please place a check next to the weeks your child will attend:

- o Week 1: June 18-21 (40% off)
- o Week 2: June 24-28
- o Week 3: July 1-5 (40% off)
- o Week 4: July 8-12
- o Week 5: July 15-19
- o Week 6: July 22-26
- o Week 7: July 29-August 2
- o Week8: August 5-9
- o Week 9: August 12-16

Late Pick-ups

_____ Summer Learning Programs end at 5:30pm. If you are late picking up your child, there will be a cost of $1.00 per minute. Late fees are billed directly through the ProCare account, and an invoice is automatically generated and emailed to you. Please see the Parent Handbook for more information.

Program Requirements

_____ Students are expected to attend at least 80% of the time (4 days per week).

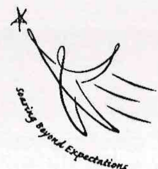
_____ Students and parents/guardians are expected to participate in surveys and forums that help with data collection needed for grant reporting throughout the year.

_____ Parents/guardians are expected to participate in family engagement activities at least three times per year.

Tuition Assistance

Childcare subsidy programs exist to help cover weekly tuition costs if eligible. Applying for tuition assistance can take some time so please do not delay this process. A VALID CONTRACT IS NEEDED BEFORE ANY CHILD CAN BEGIN.

The 21st Century Community Learning Center is a federally funded program supported by the New Jersey Department of Education for out-of-school-time programs in New Jersey, which include those before school, after school or in the summer.



Camp Horizon is made possible through funding from the United Way of Gloucester County and the County of Gloucester.

FOR STAFF USE ONLY:			Initial
1 2 3 4 5 6 7 8	Initial	Enter/Update ProCare	____
Packet Complete	____	CCFP-(1) copy file, orig. office	____
Fee Agreement	____	ER form-(2) copy office, site, orig. file	____
Registration Paid	____	Photo (1) copy office, orig. file	____
1st Payment Paid	____	File in Child's Confidential Folder	____
Parent Handbook Sent	____	Welcome email sent: ____________	____
		Rutgers prepapas completed: ____________	
		Contract received:	

EMERGENCY AND RELEASE INFORMATION

Child's Name: ______________________

Date of Birth: ______________________

Address: ______________________

____

Phone: ______________________

SITE: __________

Parent 1 Contact Information

Name: ______________________

Address (if different): ______________________

____

Cell Phone: ______________________

Email: ______________________

Employer: ______________________

Work Phone: ______________________

Parent 2 Contact Information

Name: ______________________

Address (if different): ______________________

____

Cell Phone: ______________________

Email: ______________________

Employer: ______________________

Work Phone: ______________________

Is there a court order (custody or restraining order) involving this child? ☐ **Yes** ☐ **No**

(If yes, we must have a copy, complete with judge/clerk's signature and date)

PARENTS WILL BE CALLED FIRST IN CASE OF EMERGENCY!

IF PARENTS ARE NOT AVAILABLE, THE PERSONS LISTED BELOW WILL BE CONTACTED IN THE ORDER THEY ARE LISTED. PLEASE NOTE: ONLY THE PERSONS LISTED ON THIS FORM ARE AUTHORIZED TO PICK UP YOUR CHILD.

Authorized Pick-Up #1

Name: ______________________ Relationship: ______________________

Phone #: ______________________ Address: ______________________

Authorized Pick-Up #2

Name: ______________________ Relationship: ______________________

Phone #: ______________________ Address: ______________________

Authorized Pick-Up #3

Name: ______________________ Relationship: ______________________

Phone #: ______________________ Address: ______________________

Authorized Pick-Up #4

Name: ______________________ Relationship: ______________________

Phone #: ______________________ Address: ______________________

Authorized Pick-Up #5

Name: ______________________ Relationship: ______________________

Phone #: ______________________ Address: ______________________

Authorized Pick-Up #6

Name: ______________________ Relationship: ______________________

Phone #: ______________________ Address: ______________________

EMERGENCY MEDICAL CARE

This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this Childcare program. Feel free to continue your notes on an attached separate sheet.

1. If my child requires emergency medical care and I cannot be reached, I give my consent to Glassboro Child Development Centers to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.
2. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.

Student's Doctor: ______________________

Phone: ______________________

Last Tetanus: ______________________

Allergies: ______________________

Doctor's Address ______________________

Insurance Company: ______________________

Policy Holder's ID: ______________________

Child's Social Security #: ______________________

Religious Preference: (optional) ______________________

Please provide your child's medical history.

CONDITION	YES	NO
Asthma		
Does your child use an inhaler?		
Convulsions/Seizures		
Diabetes		
Ear Infections		
Chicken Pox		
Measles		
German Measles		
Rheumatic Fever		
Mumps		
Corrective Device (glasses, hearing aid, etc.)		
Any significant illnesses or surgeries?		
**If "yes" to any of the above, please provide the date or any further details.		

ALLERGY	YES	NO
Penicillin		
Insect Stings		
Foods		
Plants		
Hay Fever		
Topical ointments		
Other		
**If "yes" to any of the above, please describe reaction.		
Does your child have an EpiPen®?		

Special situations or needs that staff should be aware of:
☐ Child has behavioral /emotional difficulties
☐ Child has physical disabilities
☐ Child has IFSP, IEP, or 504 Plan. *We must receive this prior to first day of attendance.

Special Health Care Needs

If yes, the following forms are **<u>required</u> prior to first date of attendance: the Administration of Medication, Food Allergy Action Plan, or Asthma Action Plan as needed. Medical forms are available for pick up at our main office and must be completed and signed by a health care physician.

I understand that this consent will be in effect as of the date of my signing and will continue as long as my child is enrolled in GCDC programs.

____

Parent/Guardian Signature   Date

Glassboro Child Development Centers

Photo Release Form

Please select site:

☐ Preschool
☐ RASKEL@Rodgers
☐ Horizon @Bullock-Grades1-2
☐ JURASSIC@Bullock-Grades 3-5
☐ JURASSIC@Bowe-Grades 6-8

I, ______________________________________, herby ____consent/____do not consent to and authorize Glassboro Child Development Centers the right to use the name of, photograph or likeness of, and statements made by _________________________________ (child's name), a minor, in support of the commercial and noncommercial activities, including fundraising operations, videos and social media.

The undersigned acknowledge that no compensation or payment shall be made by the Glassboro Child Development Centers in return for this consent or authorization on the use publication of name, the photograph or likeness of video films or statements of this minor.

This release shall remain in continuous effect until withdrawn in writing by the undersigned.

Child's Name: ____ Date of Birth: _______

Parent/Guardian's Name (print): ____

Parent/Guardian's Signature: ____

Address: ____

Date: _______________________ Witness: _____________________________________

PARENT HANDBOOK /POLICY RECEIPT ACKNOWLEDGEMENT

Dear Parent:

In keeping with New Jersey's child care center-licensing requirements we are obligated to provide you, as the parent of a child enrolled at our center, with this statement as well as other policies attached.

Please read the policies and if you have any questions, feel free to contact us at 856-881-3331.

Sincerely,

Joan E. Dillon, Executive Director

Please complete and return this portion to the center. (Please print)

I, ______________________________, have received the following policies for Glassboro Child Development Centers, outlined in the parent handbook for my child's program:

___ Administration of Medication
___ Breastfeeding *(Preschool Only)*
___ Communicable Diseases
___ Completion of Assessment *(Preschool Only)*
___ Diapering *(Preschool Only)*
___ Fee Policies
___ Hand Washing Guidelines
___ Information to Parents
___ Nutrition and Physical Activity
___ Parent Grievance
___ Right to Refuse Services
___ Screen Time
___ Supervision of Children
___ Toilet Training *(Preschool Only)*
___ Attendance *(Preschool Only)*
___ Discipline/Expulsion
___ Communication/Notification
___ Dental Health *(Preschool Only)*
___ Family Engagement
___ Transportation
___ Inaccessibility to Toxic Substances
___ Late Pick Up
___ Parent/Family Code of Conduct
___ Release of Children
___ Safe Sleep *(Preschool Only)*
___ Screening/Referral *(Preschool Only)*
___ Transition *(Preschool Only)*
___ Use of Technology and Social Media

I agree to abide by the above policies AND other procedures contained in the parent handbook.

____
Parent/Guardian signature

____
Date

____
Agency Witness

Names of child/children:

____

____

____

**** THIS PAGE MUST BE RETURNED BEFORE YOUR CHILD ENTERS OUR PROGRAM.**

BLANKET PERMISSION SLIP

Note: A specific Permission Slip will be given to you for every trip. In the event that we have not received a completed form, or your child was absent at the time the forms were distributed, this Blanket Permission Slip Form will be used along with your verbal permission.

When signed below, this form allows your child to participate in the following activities and services offered by Glassboro Child Development Centers:

- Supervised activities at the center
- Supervised walks around the neighborhood
- Emergency treatment by a physician or dentist in their office or at a hospital (as determined by qualified personnel or the EMT in Glassboro).

Permission is given for all the activities and services specified above by signing this form. My child is in good health and can participate in the normal activities of the GCDC programs. Furthermore, any conditions or special needs that may require special accommodations are described below.

____

____

____

____

____

Child's Name: ________________________________

Parent/Guardian Signature: __________________________

Relationship to Child: ____________________________

Date: ______________

Glassboro Child Development Centers

INDIVIDUAL PERMISSION FOR TOPICAL OINTMENT & CREAM ADMINISTRATION

Name of Child: DOB:

Type of non-prescribed ointment to be administered:

- ☐ Sunscreen
- ☐ Diaper Rash
- ☐ Bug Repellant
- ☐ Other: ______________________

*Being mindful of our students with asthma and allergies, we do **not** permit spray or aerosol cans to be sent in.

*Special Notes: ______________________

Amount to be administered: ______________

Times to be administered: ______________

Dates to be administered: ______________

Location to be administered to: ______________

Parent/Guardian Name:

Parent/Guardian Signature:

(My signature indicates I understand I must apply the first application of the morning prior to drop off)

Phone Number: ______________

Date: ______________

Program/Site: ______________

☐ My child is under the age of 10 years and requires a staff member to apply the topical ointment, while wearing gloves.

☐ My child is 10 years old or above and can apply their own topical ointment.

I authorize the administration of ointment for my child, ______________________, to receive the above-mentioned ointment according to the directions. I confirm that I have applied at least one application of this ointment without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the ointment in its original container, that has been labeled with my child's full name. I UNDERSTAND I MUST APPLY THE FIRST APPLICATION OF THE DAY, PRIOR TO DROP OFF AT GCDC PROGRAMS. I authorize the Director or designated GCDC Staff to apply the above-mentioned ointment.

Signature of Parent/Guardian: ______________________ Date: ______________

FOR CENTER USE:

- ☐ Is all the above information complete?
- ☐ Has the ointment been made inaccessible to children?
- ☐ Is the ointment in the original container?

Glassboro Child Development Centers

☐ Is the child's name on the container?

Ointment that has been provided: ______________________________

Date: ____________________ Parent Signature: ____________________________

Date: ____________________ Director Signature: ____________________________

Date **ointment was returned to Parent**: ______________________________

Date: ____________________ Parent Signature: ____________________________

Date: ____________________ Director Signature: ____________________________

Date(s) Administered:	Time(s) Administered:	Adverse Reactions Observed:	Staff Initials:

2024 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT(S)____
(Name) (Age) (Name) (Age)

OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT

Check one ETHNIC identity:

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

Mark one or more RACIAL identity (ies):
[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander [ ] White

Enrollment Information

Check ( ) each day the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:

DAYS OF CARE: ☐MON ☐TUES ☐WED ☐THURS ☐FRI ☐SAT ☐SUN

HOURS OF CARE: ___-___ ___-___ ___-___ ___-___ ___-___ ___-___ ___-___
Swing / Rotating Shifts: (If Applicable) ___-___ ___-___ ___-___ ___-___ ___-___ ___-___ ___-___

MEAL TYPES SERVED: ☐BREAKFAST ☐A.M. SUPPLEMENT ☐LUNCH ☐P.M. SUPPLEMENT ☐DINNER

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) *(formerly Food Stamps)*, **Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)**

If you are now receiving SNAP,TANF or FDPIR for this child, complete __one__ of the following numbers:

SNAP CASE #____________________ OR TANF CASE #_____________________ OR FDPIR CASE #______________

OPTION 1B: FOSTER CHILD

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD INCOME $____________

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete __one__ of the following numbers:

SNAP #______________ OR FDPIR CASE #__________________ OR SSI CASE # __________________ OR MEDICAID CASE #___________________

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*)	MONTHLY INCOME (*Complete One Or More - Before Deductions*)				
	Monthly (Gross Earnings) Wages/Salary	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	Monthly Any Others Income
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$
7.	$	$	$	$	$
8.	$	$	$	$	$
9.	$	$	$	$	$
10.	$	$	$	$	$

TOTAL NUMBER IN HOUSEHOLD *(INCLUDE ENROLLED PARTICIPANT)*: ________

TOTAL GROSS HOUSEHOLD INCOME: $ ______________

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: *(See Privacy Act Statement below)*
An Adult Household Member must sign and date this form and list the last four (4) digits of his or her Social Security Number.
If you do not have a social security number, mark the box ☒ I do not have a Social Security Number".

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information, and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Member must complete the following:***

Signature: ______________________________ Address:______________________________________

Print Name: ____________________________ City: ____________________State: ______________Zip Code:_________

Date: ________________ Phone Number:__________________________

Last four (4) digits of Social Security Number: *_ _*_*_ - _*_*_ - ____________ ☐ I do not have a Social Security Number

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, and investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

Determination: Free _________Reduced __________ Paid __________
Signature of Determining Official:
____________________________________ Date__________

TOTAL MONTHLY INCOME $________________
Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15

2023-2024 CHILD AND ADULT CARE FOOD PROGRAM LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced- priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. U.S Department of Agriculture, Office of the Assistant of Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250; or 2. Fax (833) 256-1665 or (202) 690-7442; or 3. Email: program.intake@usda.gov

Glassboro Child Development Centers — (856) 881-3331

(Name of Day Care Center) — ***(Day Care Center Phone Number)***

New Jersey Department of Agriculture Child and Adult Care Food Program — ***Phone Number 609-984-1250***

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names)*.
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. *(One time requirement for Adult Day Care participants.)*

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY:

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

3. Names of all *(Related or Unrelated)* household members
4. List the household income *(Monthly Gross Earnings)* for each household member.
5. Total number in household *(#1 + #3 above)*.
6. Total the gross income of all household members.
7. Sign, Print and complete the full address of the Adult Household Member signing the application.
8. Date the form and complete the telephone number of Adult Household Member signing the application.
9. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE Effective from July 1, 2023 to June 30, 2024

HOUSEHOLD SIZE	REDUCED ANNUAL	MONTHLY	WEEKLY
1	$18,955 - $26,973	$1,581 - $2,248	$ 366 - $ 519
2	$25,637 - $36,482	$2,138 - $3,041	$ 493 - $ 702
3	$32,319 - $45,991	$2,695 - $3,833	$ 623 - $ 885
4	$39,001 - $55,500	$3,251 - $4,625	$ 751 - $1,068
5	$45,683 - $65,009	$3,808 - $5,418	$ 880 - $1,251
6	$52,365 - $74,518	$4,365 - $6,210	$1,008 - $1,434
7	$59,047 - $84,027	$4,922 - $7,003	$1,137 - $1,616
8	$65,729 - $93,536	$5,479 - $7,795	$1,265 - $1,799
Each Additional Family Member	+9,509	+793	+183