



Boulder County Child Care Assistance Program (CCAP) Check-List

In order for your household to be determined for CCAP benefits you will need to turn in the following to the County Office:

- Your completed and signed CCAP application- this can be done online through PEAK.
Complete this application to the best of your ability. You must complete all sections marked with an asterisk.

~AND~

- Verification of County Residency: this can be a current utility bill, current lease, current landlord letter, or current auto registration.
- Verification of Identity: this is an unexpired government issued picture ID for child. If unavailable, please submit verification of identity for the primary adult applicant
- Verification of Citizenship: this is a copy of a US birth certificate or US passport for all children requesting care.
- Verification of all EARNED income for all adults on CCAP case:
- VOE- Verification of Employment letter for any **NEW** employment (within last 60 days); **OR**
 - Last 30 days of current paystubs for ESTABLISHED employment **older** than 60 days; **OR**
 - Self- Employed persons:
 - Please provide your last 30 days of current income and hours worked.
- Verification of any UNEARNED income: Including but not limited to Child Support, Unemployment, or Social Security.
- If in school/training activity: Verification of Program of Study and Unofficial Transcript
- Verification of eligible activity schedule: only if care is needed outside of traditional care hours of 6am to 630pm Monday-Friday.
- Child Visitation Schedule: Complete the attached visitation form if the child(ren) you are requesting care for have visitation with a non-custodial parent.
- Child Care Provider/ Location/ License number (* see below for Child Care Referral Information)

Please Note: This is not an inclusive list and there may be other items needed based on your individual circumstances, the technician working your case will let you know if other verification is needed.

If you are needing assistance in finding a quality rated child care provider, please visit the Colorado Shines website at <http://coloradoshines.force.com/families?p=How-to-Find-Quality-Child-Care>. You may either contact the Colorado Shines Child Care Referral at Mile High United Way for your free referral list at 877-338-CARE or 877-338-2273 or search the Colorado Shines database at <http://www.coloradoshines.com/search>.



WHO IS ELIGIBLE? Boulder County Children ages 0 months to 12 years who live with:

- An adult or teen caretaker/parent that is in an eligible activity
 - Employed/ self-employed
 - Job Searching (thirteen weeks)
 - Post-Secondary Educational Activities (104 weeks and up to first Bachelor’s degree)
 - Educational Activities (teen parents in JR or SR High School, GED classes, ESL, and Adult Basic Ed/ Vocational Training)
- Families receiving Colorado Works/TANF and referred by their Case Manager

INCOME ELIGIBILITY: Must be within the current posted income guidelines (subject to change)

Household Size	2	3	4	5	6	7
265% FPG	\$3,734.29	\$4,710.38	\$5,686.46	\$6,662.54	\$7,638.63	\$8,614.71

PROGRAM REQUIREMENTS:

- Must be County Resident,
- Must pay a portion of care or parent fee based on household income,
- Must choose a CCAP eligible child care provider,
- Must be approved ***before*** using care,
- And for continued assistance you must complete the CCAP redetermination process every twelve (12) months.

CCAP technician will determine eligibility based on information provided by you on your application and any verification submitted or obtained to support application statements. Once you are determined eligible you will be notified as well as your child care provider as to care authorized. It is required that you use the ATTENDANCE TRACKING SYSTEM (ATS) utilized for CCAP by your provider. Non-cooperation with the use of the ATS program may result in case closure and/or non-payment of the child care subsidy.

For further assistance with this process contact the
 Boulder County CCAP Team at:
 303.441.1000 or
 Email imaging@bouldercounty.org
www.bouldercountyccap.org

Application Received Date:	Pre-Eligibility: Yes <input type="checkbox"/> No <input type="checkbox"/> Determined by: Provider <input type="checkbox"/> County <input type="checkbox"/>	Case Number:
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Application for Colorado Child Care Assistance Program. (CCCAP)

- **Completion of this application does not guarantee you will receive child care assistance.**
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please provide all requested information
- Missing information will delay your application.
- **Teen Parents:** Do not include information about your parents even if you live with them.

Section 1: Household Information

Today's Date: ____/____/____	If you are not the parent of child(ren) for whom you are applying, are you the Primary Adult Caretaker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there other Adult Caretaker(s) in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Adult Caretaker's Last Name:	Primary Adult Caretaker's First Name:	Middle Initial:
Do any of the following apply to your current living situation? Please complete if applicable.	<input type="checkbox"/> Living in hotel or motel	<input type="checkbox"/> Living in campground
	<input type="checkbox"/> Living in shelter	<input type="checkbox"/> Living in substandard housing such as car, park, etc.
	<input type="checkbox"/> Other irregular living situation (please explain)	Date living situation began: ____/____/____
		Anticipated end date: ____/____/____
Residence Address:		Mailing Address: <input type="checkbox"/> Same as residence?
City:	State:	Zip:
City:	State:	Zip:
County:	Primary language spoken in the home:	
Contact Information: <i>Complete at least one</i>	Primary Phone: () Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	Secondary Phone: () Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work
Email Address:		
Do you or anyone else in your household receive benefits from or participate in any of the following programs?		If no, would you like to receive more information?
Colorado Works/TANF cash assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Start/Early Head Start	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low-Income Energy Assistance (LEAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Assistance (SNAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Women, Infants and Children (WIC) Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child and Adult Care Food Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid/CHP+ Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Housing voucher or cash assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Refugee Medical Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individuals with Disabilities Education (IDEA) Services Part B (3-5yrs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individuals with Disabilities Education (IDEA) Services Part C (0-3yrs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Old Age Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (please explain): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



Section 2: Primary Caretaker Information

Last Name:		First Name:		Middle Initial:
Social Security Number: _____ - _____ - _____ (Optional)		Date of Birth (MM/DD/YYYY): ____/____/____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White	
Highest Grade Completed:	<input type="checkbox"/> Less Than High School/High School Equivalency	<input type="checkbox"/> High School/High School Equivalency	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor Degree
	<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> PhD/Doctorate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
Marital Status:	<input type="checkbox"/> Married, Living w/Spouse	<input type="checkbox"/> Married, Not Living w/Spouse (voluntarily)	<input type="checkbox"/> Married, Not Living w/Spouse (involuntarily)	
	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single – Never Married	<input type="checkbox"/> Widowed/Widower	<input type="checkbox"/> Divorced
ACTIVITY: Check all that apply to this individual				
<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Job Search	<input type="checkbox"/> Post-Secondary School	
<input type="checkbox"/> Training/Education	<input type="checkbox"/> English as a second language	<input type="checkbox"/> GED/High School Equivalency	<input type="checkbox"/> Middle / Jr. High	
<input type="checkbox"/> Disabled	<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	<input type="checkbox"/> Active Military (serving full time)	

Section 3: Additional Adult Caretaker/Spouse

An additional adult caretaker in the household is one who provides financial assistance and helps care for your child

Last Name:		First Name:		Middle Initial:
Social Security Number: _____ - _____ - _____ (Optional)		Date of Birth (MM/DD/YYYY): ____/____/____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White	
Highest Grade Completed:	<input type="checkbox"/> Less Than High School/High School Equivalency	<input type="checkbox"/> High School/High School Equivalency	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor Degree
	<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> PhD/Doctorate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
Marital Status:	<input type="checkbox"/> Married, Living w/Spouse	<input type="checkbox"/> Married, Not Living w/Spouse (voluntarily)	<input type="checkbox"/> Married, Not Living w/Spouse (involuntarily)	
	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single – Never Married	<input type="checkbox"/> Widowed/Widower	<input type="checkbox"/> Divorced
ACTIVITY: Check all that apply to this individual				
<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Job Search	<input type="checkbox"/> Post-Secondary School	
<input type="checkbox"/> Training/Education	<input type="checkbox"/> English as a second language	<input type="checkbox"/> GED/High School Equivalency	<input type="checkbox"/> Middle / Jr. High	
<input type="checkbox"/> Disabled	<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	<input type="checkbox"/> Active Military (serving full time)	



Section 4: Child Information Complete this section for each child in your home

Last Name:		First Name:		Middle Initial:
Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker:	

Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Immunization status: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Religious Exemption <input type="checkbox"/> No, Medical Exemption	
Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what is their enrollment start date and end date? Start: ____/____/_____ End: ____/____/_____	
Does this child have a disability or have additional care needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 Cont'd Complete this section for each child in your home

Last Name:		First Name:		Middle Initial:
Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker:	

Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Immunization status: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Religious Exemption <input type="checkbox"/> No, Medical Exemption	
Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what is their enrollment start date and end date? Start: ____/____/_____ End: ____/____/_____	
Does this child have a disability or have additional care needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 Cont'd Complete this section for each child in your home

Last Name:	First Name:	Middle Initial:
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Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker:
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Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Immunization status: Yes, Immunized No, In Process No, Religious Exemption No, Medical Exemption

Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have a disability or have additional care needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start: ____/____/____ End: ____/____/____		

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Section 4 Cont'd Complete this section for each child in your home

Last Name:	First Name:	Middle Initial:
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Social Security Number (Optional): ____-____-_____	Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker:
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Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Immunization status: Yes, Immunized No, In Process No, Religious Exemption No, Medical Exemption

Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have a disability or have additional care needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start: ____/____/____ End: ____/____/____		

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN
Page _____ of _____



Section 5: Primary Caretaker Work/Self-Employment Income							
Do you have Work or Self-Employment income? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If YES complete the following: Please list all employment. (VERIFICATION IS REQUIRED.)							
Name of caretaker	Employer or Business Name and Telephone Number	Work/Self-Employment Start Date	Self-Employed	LLC or S-Corp?	# of hours per week	How often paid	Total earnings per pay period (including tips & commissions)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$

Section 6: Additional Adult Caretaker/Spouse Work/Self-Employment Income							
Do you have Work or Self-Employment income? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If YES complete the following: Please list all employment. (VERIFICATION IS REQUIRED.)							
Name of caretaker	Employer or Business Name and Telephone Number	Work/Self-Employment Start Date	Self-Employed	LLC or S-Corp?	# of hours per week	How Often paid	Total earnings per pay period (including tips & commissions)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$

Section 7: Court Ordered Child Support Paid Out			
Do you make child support payments for any child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES complete the following: (VERIFICATION OF COURT ORDER AND PAYMENT IS REQUIRED.)			
Name of person making payment	Child(ren) out to	Amount paid	How often paid
		\$	
		\$	

Section 8: Child Support Ordered and/or Received					
Has child support been ordered and/or has it been received? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Child Name(s)	Is child support ordered?	Is child support received?	Amount of Child Support Paid	How often paid	Name of non-custodial parent
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			



Section 9: Other Income Complete information in Section 9 for each person in your household.

Individual Name:	Effective Begin Date:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Other Income Types: Refugee Cash Assistance Social Security (Survivor's, Disability, Retirement) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Railroad Retirement Benefits Veteran's Benefits Supplemental Security Income (SSI) TANF/Colorado Works Cash Assistance Other (Describe under Individual)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____
Individual Name:	Effective Begin Date:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Other Income Types: Refugee Cash Assistance Social Security (Survivor's, Disability, Retirement) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Railroad Retirement Benefits Veteran's Benefits Supplemental Security Income (SSI) TANF/Colorado Works Cash Assistance Other (Describe under Individual)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS
 Page _____ of _____

Section 10: Adult Caretaker Training/Education/Teen Education Detail

Are you or another household member participating in a training/education activity? Yes No

If YES, complete the following: (VERIFICATION IS REQUIRED)

Name:	Effective Begin Date:	Effective End Date:
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Number of Credits:	Training Institution:	Type of Training: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> English As A Second Language (ESL) <input type="checkbox"/> Post-Secondary Education <input type="checkbox"/> GED/High School Equivalency <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date:
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Name:	Effective Begin Date:	Effective End Date:
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Number of Credits:	Training Institution:	Type of Training: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> English As A Second Language (ESL) <input type="checkbox"/> Post-Secondary Education <input type="checkbox"/> GED/High School Equivalency <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date:
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Section 11: Adult Caretaker Disability Detail

Are you or another Adult Caretaker disabled? Yes No

If YES, complete the following: (VERIFICATION IS REQUIRED)

Name:	Disability Begin Date:	Disability End Date:
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Disability Type: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Is this Individual able to take care of the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Review Due Date, if applicable:
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Name:	Disability Begin Date:	Disability End Date:
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Disability Type: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Is this Individual able to take care of the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Review Due Date, if applicable:
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Section 12: Adult Caretaker(s) Employment/Training/School/Job Search Schedule

Please fill in your expected schedule. If there are two adult caretakers, fill in schedules for both. If you have more than one job please list your work schedule for both jobs. (VERIFICATION IS REQUIRED.)

Example	Mon. 8:00a - 5:00p	Tues. 8:00a - 5:00p	Weds. 8:00a - 5:00p	Thurs. 8:00a - 3:00p	Fri. 8:00a - 5:00p	Sat. 8:00a-12:00p	Sun. 8:00a - 5:00p
MY SCHEDULE							
Work/Job Search							
Training/School							
2ND ADULT CARETAKER	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							

Section 13: Children’s Schedule for children needing care

(Do not complete for children who do not need care.)

Child Name	Child In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Grade and School Of Attendance	Child’s Schedule: Please indicate times you plan to have your child in care each day for each provider used							
			Provider License #, Name, Address and Phone # (If known)	Mon. 8:00a – 5:00p	Tues. 8:00a – 5:00p	Wed. 8:00a – 5:00p	Thurs. 8:00a – 5:00p	Fri. 8:00a – 5:00p	Sat. 8:00a – 5:00p	Sun. 8:00a – 5:00p
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									

Authorization to Supply Information

Authorization to Supply Information

I hereby authorize the County Department of Social/Human Services, in the course of administering the social services program, to supply information to any of the entities listed below. I release the county department from any and all liability for supplying such information.

- Any child care provider I may choose to use,
- any employer for whom I currently work or have worked,
- any school or training institution I may be attending
- any housing authority
- and/or any other information that may be pertinent to my application for or receipt of public assistance programs including Head Start and Early Head Start.

Authorization to Release Information

I authorize the persons, agencies, or institutions entered below to supply information to the County Department of Social/Human Services concerning my application for or receipt of social services. I also allow inspection and reproduction of records in their possession pertaining to me by any authorized representative of the county department. I release the person, agency, or institution from any and all liability for supplying such information.

- Any child care provider I may choose to use,
- any employer for whom I currently work or have worked,
- any documentation submitted for self-employment,
- any school or training institution I may be attending,
- any housing authority,
- and/or any other information that may be pertinent to my application for or receipt of public assistance programs including Head Start and Early Head Start.

Signature of Client: _____ Date: _____

Signature of Spouse and/or Other Adult Caretaker: _____ Date: _____

CLIENT RESPONSIBILITIES AGREEMENT

1. I agree to notify my child care worker in writing within ten (10) days if my total household income exceeds 85% of the State Median Income (found on www.coloradoofficeofearlychildhood.com) and report within four (4) weeks if my qualifying eligible activity changes. I understand that I must also verify these changes and that I will have to repay any benefits I received for which I was not eligible.
2. I agree that I must complete the redetermination process when it is due, including all required verification.
3. I agree that I must verify my eligible activity when there is a change in my eligible activity and at re-determination. (A schedule will be required if you are self-employed or when non-traditional care such as overnight, weekend, or evening care, is needed)
4. I agree to notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.
5. I agree to be responsible for resolving any problems I might have with my child care provider.
6. I agree to notify the County Department of Social/Human Services if I have any concerns about possible abuse or neglect of a child while in child care.
7. I understand that if any parent in my household is self-employed I/we must maintain an average income that exceeds business expenses and I agree to track and verify income, expenses, work schedule and need for care to assist in my eligibility determination.
8. I understand that if child care is provided for my employment or self-employment activity then the taxable gross wages divided by the number of hours I work must equal at least the current federal minimum wage in order to continue receiving child care.
9. I agree that if my county requires child support enforcement I will cooperate with the child support enforcement office for any child that is receiving care and has an absent parent.
10. I agree that I will use the State Attendance System as designed to check my child(ren) in and out of the child care facility.
11. I understand that a person found to have intentionally given false information by deed or omission cannot get child care assistance for twelve (12) months for the first offense, twenty-four (24) months for the second offense, and permanently for the third offense. This crime is subject to prosecution under federal and state laws.
12. PARENT FEE:
 - a. I agree to pay the parent fee listed on my child care authorization notice and that it is due to the provider in the month that care is received.
 - b. I understand that my parent fee is based on my income, household size and number of children in care and is subject to change upon receiving prior notice from the county.
 - c. I understand that if I do not pay this fee or make acceptable payment arrangements with my childcare provider, I will lose my child care benefits at re-determination and will not be able to receive assistance with another child care provider and/or through any other county.



I/WE certify that the information on this form is correct, to the best of my knowledge. I/WE understand that failure to report required changes or misreporting information may result in the recovery and/or discontinuance of my child care benefits. I have read and agree to the conditions above for receiving assistance with my child care costs

Signature of Primary Adult Caretaker: _____ Date: _____

Signature of Other Adult Caretaker: _____ Date: _____

Thank you for completing this form. If you have any questions call the Child Care Assistance Program (CCAP) at your County Department of Social/Human Services.

RIGHT OF APPEAL AND FAIR HEARING

If you disagree with any action taken in regards to child care benefits, you have a right to appeal.

- ◆ If your child care benefits are denied, you must call your child care assistance worker within fifteen (15) days of the date of that denial to say that you want to appeal.
- ◆ If your child care benefits are changed, you must call your child care assistance worker within fifteen (15) days of the date of the notice of the change to say that you want to appeal.
- ◆ If your child care benefits are terminated, you must call your child care assistance worker before the effective date of the termination to say that you want to appeal.

A hearing will be scheduled by the county department. At the hearing, you will be given an opportunity to present your case. If you appeal the decision or change, the person who officiates at the hearing shall not be the originator of the change or decision.

Before you decide to request a county hearing, we encourage you to talk with your county department child care worker first, and then the worker's supervisor. Often your questions and concerns can be settled by talking to the county staff responsible for making the change in your child care subsidy.

If after you completed a county hearing you still disagree with the decision, you may appeal the decision to the State by following these steps:

1. Write a letter to:

Office of Administrative Courts
1525 Sherman Street
4th Floor
Denver, CO 80203

2. You must appeal the county decision within 15 days of the mail date on the Notice of County Hearing Decision.
3. In the letter you need to state that you want to appeal the county hearing decision and why you want to appeal the decision. If you need help doing this you can ask anyone to help you, or talk to a legal aid office, or ask your County Social/Human Services representative to help you.
4. The Office of Administrative Courts will schedule a date for the appeal hearing if it is determined the request was filed timely. You will receive a letter from the Office of Administrative Courts explaining the next steps, who may come with you, who may present testimony and other information about the hearing.

You should be aware that the state and county are required to attempt to collect all benefits provided for which you were not eligible.

Discrimination

If you believe that you have been discriminated against because of race, color, sex, age, religion, political beliefs, national origin, or handicap, you have a right to file a complaint with:

Office for Civil Rights
U.S. Department of Health & Human Services
1961 Stout Street – Room 1426
Denver, Colorado 80294
(303) 844-2024 or (303) 844-3439 (TDD)

Keep this page for your reference



Boulder County CCAP Child Custody/Visitation Form

Please complete this required form for all children requesting CCAP care that have visitation with a parent who lives outside your home. (Fields marked with an * are mandatory)

A. CHILDREN INFORMATION *:

Child's name: please list all children in home requesting CCAP care *:	Is there a visitation agreement for this child? *: If NO, skip to signature.		Is the visitation agreement court ordered for this child? *	
1.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please provide copies or any COURT ORDERED VISITATION documents that you have for any child requesting CCAP care.

B. VISITATION SCHEDULE *: If you have a visitation agreement and do not have Court Ordered Documentation please complete the Visitation Schedule below for each child that has visitation with a parent outside your home.

Please complete schedule with times/dates child is with their other parent. Please note if child has Overnight visitation.

CHILD	PARENT	MON	TUES	WED	THUR	FRI	SAT	SUN
1.	MOTHER							
	FATHER							
2.	MOTHER							
	FATHER							
3.	MOTHER							
	FATHER							
4.	MOTHER							
	FATHER							

Please include any other information about your visitation schedule that is more specific give dates (ie. Variable schedule, rotating schedule, every other week, etc.): _____

CCAP Parent Signature/ Date



Boulder County Child Care Assistance Program (CCAP)

515 Coffman Street ~ Longmont CO 80501
 3460 N Broadway ~ Boulder CO 80304
 Phone: 303.441.1000
 Please send to:
 Imaging Email: Imaging@bouldercounty.org



Child Care Assistance Program- Verification of Employment

This form is to be completed by EMPLOYER only, all sections must be filled in to be considered complete.

CCAP Client Name: _____ Social Security #: _____

Name of Business: _____

Business Address: _____

First Day of Employment: _____ First Check Date: _____

Job Title: _____

Rate of Pay: _____ Monthly Gross Wages: _____ Taxes Withheld Yes No

How often paid? Weekly Biweekly Semimonthly Monthly/Other _____

*If tips, what percentage is reported: _____

Is this temporary employment? Yes/No. If yes, give end date _____

Is this job required to obtain college degree? Student Hourly or Work Study?

WEEKLY WORK SCHEDULE if fixed schedule

Please list typical work schedule i.e. 9a-5p -within the grid below for each day of work client is expected to work:

SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS PER WEEK

OR

If client works a **FLEXIBLE SCHEDULE**, please tell us when they are available to work:

Earliest time in _____ **am/pm** **AND** **Latest time out** _____ **am/pm**

Average Hours Per Week _____

Days of week expected to be available: **M**, **T**, **W**, **TH**, **F**, **S**, **S**

The above person has indicated that s/he is employed with your business. Please complete the following information and return to employee or directly to CCAP at the address or number at the bottom of page.

I confirm that the above information is complete and accurate:

Printed Name

Title

Phone Number

Signature

Date

**3460 N. Broadway, Boulder, CO 80304 OR
515 Coffman Street, Longmont, CO 80501**

**Phone: (303) 441-1000 or email to
sboulderimaging@bouldercounty.org**

UNRELATED INDIVIDUALS QUESTIONNAIRE

Participant Name: _____ **Case#:** _____

The Colorado Child Care Assistance program (CCCAP) must determine if an unrelated adult living in your home acts as a parent to your child (ren) and provides financial support to you and your child (ren). Please answer the following questions.

IS THERE ANYONE LIVING IN YOUR HOUSEHOLD WHO IS NOT RELATED TO YOU OR YOUR CHILD (REN)?

YES. Name of Individual: _____. Please answer all questions in sections A and B below.

NO. Please skip ahead to section C.

A. Financial Assistance: Does the unrelated individual living in your home provided any of the following to you or your child (ren):

Routinely pays medical bills for any member of your family	YES <input type="checkbox"/> NO <input type="checkbox"/>
Provides health insurance for any member of your family	YES <input type="checkbox"/> NO <input type="checkbox"/>
Allows you to use their debit or credit cards	YES <input type="checkbox"/> NO <input type="checkbox"/>
Maintains a joint bank account with anyone in your family	YES <input type="checkbox"/> NO <input type="checkbox"/>
Owens /buying a motor vehicle jointly with any member of your family	YES <input type="checkbox"/> NO <input type="checkbox"/>
Owens/ buying real estate, including your home, with nay member of your family	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pays 100% of the shelter/utility costs for you and your family	YES <input type="checkbox"/> NO <input type="checkbox"/>

B. Parenting: Does the unrelated individual living in your home provided daily decision-making and guidance for your child (ren):

Routinely purchase clothing for your child(ren)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pays fees for school activities/ tuition	YES <input type="checkbox"/> NO <input type="checkbox"/>
Decides your child(ren)'s future about schooling/religion	YES <input type="checkbox"/> NO <input type="checkbox"/>
Provides discipline to child (ren)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Routinely helps with homework/projects	YES <input type="checkbox"/> NO <input type="checkbox"/>
Attends school activities/ conferences	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is recognized at school, child care or doctor's office as being able to sign in your place	YES <input type="checkbox"/> NO <input type="checkbox"/>
Makes decisions about daily living activities such as bedtime, clothing, social activities	YES <input type="checkbox"/> NO <input type="checkbox"/>

C. I attest that the above information is true and correct.

Participant Sign _____ Date _____

Colorado Voter Registration Form

Fill out all fields marked with an asterisk (*). Follow the instructions for other fields. If you do not provide all of the required information, your application to register to vote will not be complete.

For office use only

Voter ID Number: _____
Date Stamp: _____

Your eligibility to vote

Are you a citizen of the United States?* Yes No
Will you be at least 18 years of age on or before the next Election Day?* Yes No
If you answered "No" to either of the above questions, do not complete this form.

Your name

Last name* First name* Middle name

If you are currently registered to vote with a different name, what is that name? _____

Your identifying information

Your birthdate* (MM/DD/YYYY) Your gender Female Male

You must select one of the following and provide the requested information*

- I have a valid Colorado Driver's License or Colorado ID card (issued by the Dept. of Revenue) and that number is - -
- I have not been issued a Colorado Driver's License or ID card, but I have a Social Security Number & the last 4 digits are -
- I do not have a Colorado Driver's License, ID card, or a Social Security Number.

Your contact information

Your home address

Street address (No P.O. Boxes)* Apt. or Unit City or Town* ZIP Code* Colorado County

When did you move to this address?* (MM/DD/YYYY)

Address where you receive your mail (required if different from your home address)

Mailing address Apt. or Unit City or Town State ZIP Code

Your former address

If you are changing your registration to a new address, you must provide the address where you were formerly registered to vote.

Street address (No P.O. Boxes) Apt. or Unit City or Town State ZIP Code

Your phone number and email

Area code Phone number Email address

Select or change your political party affiliation

Select only one. (Required if you want to vote in a party's Primary Election or participate in a party caucus).

American Constitution Americans Elect Democratic Green Libertarian Republican Unaffiliated

Voting by mail - Do you wish to be designated as a permanent mail-in voter?

- Yes, I want to be a permanent mail-in voter and automatically receive a mail-in ballot for all applicable elections.
- No, I do not want to be a permanent mail-in voter and if my name is on the permanent mail-in list I want it removed.
- No, but I would like a mail-in ballot for this year's statewide elections.

If you want mail-in ballots only for certain elections or have different mailing addresses during certain times of the year, you will need to fill out a separate Mail-in Ballot Application.

Helping with elections

I would like to be an election judge or poll worker. Yes No

Sign or mark below

WARNING: It is a crime to swear or affirm falsely as to your qualifications to register to vote.

A violation of the self-affirmation, of which you are about to make, is a criminal act under Colorado law and you will be subject to the penalties provided by law.

Self-Affirmation: I do solemnly affirm that I am a citizen of the United States and that on the date of the next election I shall have attained the age of eighteen years and shall have resided in the state of Colorado at least 30 days and in my present precinct at least 30 days before the election. I further affirm that the present address I listed herein is my sole legal place of residence and that I claim no other place as my legal residence. I am aware that I can only legally vote in one place in any election and if I register to vote in Colorado I am also considered a resident of Colorado for income tax and motor vehicle registration and operation.

Sign here

Signature or Mark* _____

Date* _____

Witness Signature _____

Date _____

(If you are registering for a Mail-in Ballot and are unable to sign, you must make a mark and a witness to the mark must sign here).

Information about this registration

How do I turn in this form?

Sign the form. Then mail, deliver, or scan the signed form and email it to your county clerk and recorder. You may find a list with contact information at www.elections.colorado.gov.

You may also mail it to
Colorado Department of State
Elections Division
1700 Broadway, Suite 200
Denver, CO 80290

If I don't know my Colorado driver's license or Colorado ID card number may I provide my Social Security Number instead?

No. If you have a Colorado Driver's License or ID card issued by the Colorado Department of Revenue, you must provide that number for your application to be complete.

How will I know if my registration was processed?

You will receive an official information card from your county clerk and recorder's office approximately 20 days after they receive your registration form.

You may also check your status at the Colorado Secretary of State website by visiting www.sos.state.co.us, clicking on the "verify/update my voter registration" link.

Am I eligible to register to vote?

You are eligible to vote if you:

- will be 18 years of age or older at the time of the next election
- are a United States citizen
- are a Colorado resident and have lived in your current precinct for at least 30 days before the election
- are not serving a sentence (including parole) for a felony conviction

Who should I contact if I have more questions?

Contact your county clerk and recorder. You may find a list with contact information at www.elections.colorado.gov.

You may also contact the Secretary of State's office

Phone: 303-894-2200 ext. 6307

Fax: 303-869-4861

Email: State.ElectionDivision@sos.state.co.us

Other frequently asked questions about registering and voting

Will I need identification to vote?

If you vote in person, yes. If you are voting by mail for the first time, you may need to provide a photocopy of your ID.

A complete list of acceptable forms of identification is at the bottom of this page.

When is the last day to register to vote?

29 days before an election.

What is mail-in voting?

If you choose not go to the polls on Election Day, you may apply to vote by mail-in ballot.

Under Colorado law, your Mail-in Ballot Application must contain your printed name, signature, residence address, mailing address if you wish to receive the ballot by mail, and date of birth. If you do not provide all of this information, you may not receive a mail-in ballot according to the rules established by the Secretary of State. [Section 1-8-104(6), C.R.S.]

What is permanent mail-in voting?

If you choose to be placed on the list of permanent mail-in voters, you will receive a mail-in ballot for every applicable election. Alternatively, you may ask for a mail-in ballot for a specific election or the calendar year.

What is the deadline for requesting a mail-in ballot?

If you want a mail-in ballot sent to you by mail, your county clerk and recorder must receive your application no later than the close of business on the 7th day before the election. If you want to pick up your mail-in ballot, you must apply no later than the Friday preceding the election. If you mail your application, make sure to allow time for delivery.

May I register to vote if I was arrested for or convicted of a crime?

Yes, if you

- are on probation for either a misdemeanor or felony
- are a pretrial detainee awaiting trial
- are currently in jail serving a misdemeanor sentence only
- have served your sentence for a felony conviction, including any period of parole

Once you have served your complete sentence, you are automatically eligible to register to vote. If you were previously registered, that registration will have been canceled and you must re-register if you wish to vote.

Acceptable forms of identification when voting

If your form of identification shows your address, that address must be in the state of Colorado.

- a valid Colorado driver's license
- a valid identification card issued by the Department of Revenue in accordance with the requirements of Part 3 of Article 2 of Title 42, C.R.S.
- a valid U.S. passport
- a valid employee identification card with a photograph of the eligible elector issued by any branch, department, agency, or entity of the United States government or of this state, or by any county, municipality, board, authority, or other political subdivision of this state
- a valid pilot's license issued by the Federal Aviation Administration or other authorized agency of the United States
- a valid U.S. military identification card with a photograph of the eligible elector
- a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the elector. For examples, please visit: www.elections.colorado.gov
- a valid Medicare or Medicaid card issued by the Centers for Medicare and Medicaid Services
- a certified copy of a U.S. birth certificate for the elector issued in the United States
- certified documentation of naturalization
- a valid student identification card with a photograph of the eligible elector issued by an institute of higher education in Colorado, as defined in section 23-3.1-102(5), C.R.S.
- A valid veteran identification card issued by the United States department of veterans affairs veterans health administration with a photograph of the eligible elector.
- A valid identification card issued by a federally recognized tribal government certifying tribal membership.