WELCOME TO THE BOULDER CHILD CARE ASSISTANCE PROGRAM!

The Colorado Child Care Assistance Program (CCCAP) utilizes the electronic CO Care Attendance System (ATS), which requires internet access and a compatible device: tablet, laptop, desktop or smart phone. Providers with an approved ATS Waiver are given permission to bill CCCAP via a Manual Claim.

The attached Boulder CCAP Manual Claim form is to be used monthly for attendance and billing (sample below). Please list all authorized Boulder CCAP children in your care. You must fill out this form in ink and return it to the county in order to receive payment for your services. You must keep a record of attendance check in/out signatures. These may be requested to support a Manual Claim.

Each county may have specific timelines for submission of the billing form. However, Bills are due within 60 days of care, with best practice of completing and submitting the claim by the 5th of the following month. If you do not submit your bill within 60 days, you will not be paid for those services. Counties have 15 days to process the manual claim. Payments are released at midnight the day the claim is processed.

Please submit bills to:

Boulder County DHHS
CCAP Program
515 Coffman street
Longmont, CO 80501
ccapbilling@bouldercounty.org
303.441.3354
## Child Care Attendance Record and Billing Form

**County:** BOULDER

**Provider Legal Name:**

**Address:** _City, State, ZIP:_

**Month / Year:**

### THIS IS A LEGAL DOCUMENT. PLEASE RETAIN A COPY FOR YOUR RECORDS.

**Acceptable Billing Codes:**
- **F** - Full Time (>5:01hrs)
- **P** - Part Time (<5.00hrs)
- **B/A** - Before/Afterschool (<5.00hrs)

**List Each Child Alphabetically**

<table>
<thead>
<tr>
<th>Case #</th>
<th>Age</th>
<th>Fund Source</th>
<th>REASON FOR BILL (required):</th>
</tr>
</thead>
</table>

- Please enter a reason for this bill (i.e. Days not paid through ATS, ATS or system error, etc.).

**County use only**

**Enter the name that is on your child care**

**Enter FULL Mailing address**

**Enter Provider License#**

**Enter Provider ID / License #**

**Provider ID / License #**

**Total Days** | **Rate Per** | **Sub Total** | **Parent Fee Y/N** | **Total**
---|---|---|---|---

**Total**

**Total # days being billed for this child, CCAP rate for care, subtotal, Parent fee deducted**

**Print E-mail address**

**Enter phone number**

**Provider Signature**

**Date**

**Please return to:**

**Boulder County DHHS**

**CCAP Program**

**515 Coffman St**

**Longmont, CO 80501**

**303-441-3354**

**ccapbilling@bouldercounty.org**

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**Enter child’s Legal Name - Last Name, First Name, MI**

**1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31**

**Case #**

**Age**

**Fund Source**

**County use only**

**Reason for Bill (required):**

**Enter child’s case number**

**Enter child’s age at time of care**

**Please enter a reason for this bill (i.e. Days not paid through ATS, ATS or system error, etc.).**

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**ONE MONTH PER BILL ONLY**

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**Print:**

**Enter FULL name of child**

**Use codes from above to fill in the days you are billing for this child**

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**Complete any additional children**

**Complete any additional children - add pages as needed for more than three children**

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**I certify the Child Care Claim Form is accurate and complete for care provided and for which payment has not been received through the State CCAP Attendance Tracking System.**