

BOULDER COUNTY CCAP SUPPLEMENTAL APPLICATION FORM

(for use with the State Public Assistance Application for determining CCCAP eligibility)

CLIENT NAME: _____ CASE ID# _____

EMAIL ADDRESS: _____ @ _____

Housing/Homeless Information:	
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 shelter
<input type="checkbox"/> Living in campground	<input type="checkbox"/> Living in substandard housing such as car, park, etc.
	<input type="checkbox"/> Other irregular living situation (please explain)
Date this living situation began:	Anticipated end date:

Additional Benefit Information:

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?

Program Area:	Receiving:	More info needed:
Head Start/Early Head Start	<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
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
Other (please explain):	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

CCAP Eligible Activity: All adult caretakers must be in an eligible activity to receive CCAP. Check all that apply for each adult:

Name:				
<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 (ESL)	<input type="checkbox"/> GED/High School Equivalency	<input type="checkbox"/> Middle/Jr. High	<input type="checkbox"/> Disabled (more information may be needed)	
<input type="checkbox"/> Active Military (serving full time)		<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	

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<input type="checkbox"/> Active Military (serving full time)		<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	

COMPLETE BOTH SIDES OF THIS FORM

Child Information: Complete for every child in the home.

Child Name:		
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 enrolled in a Head Start/Early Head Start Program? <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	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?
Immunization status: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In process <input type="checkbox"/> No, Religious/Medical Exemption		
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 not 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		

Child Name:		
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 enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> YES <input type="checkbox"/> NO
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COMPLETE ADDITIONAL SHEETS FOR ANY ADDITIONAL CHILDREN IN THE HOME

