***3460 N. Broadway, Boulder, CO. 80304 OR 515 Coffman Street, Longmont, CO 80501***
***Phone: 303 441-1000 Fax: 303 441-1523***

**Boulder County Child Care Assistance Program (CCAP)**

**Verification of Temporary Leave**

The following information is necessary to determine eligibility for Child Care Assistance Program for your employee, please complete the following form and sign:

| | |
|---|---|
| Please give this form to your employer and ask them to complete and fax back the completed form to: **(303)441-1523.** or email ccap@bouldercounty.org | Attention CCAP Worker: _____ |

Date: _____

Employee Name: _____ SS#: _____

Name of Employer: _____

Employer Address: _____

City/State/Zip

Date Leave Starts: _____ Expected Return Date: _____

Last Check Date Before Leave: _____ Is Temporary Leave: ☐ Paid ☐ Un-paid

If Paid: How often Paid?: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly/Other _____

Will The Employee Be Receiving Short Term Disability? ☐ Yes ☐ No

If so, how often?: _____ How much?: _____

**Employee's Pay /Work Schedule Upon Return:**

Weekly Work Schedule – Please fill in the weekly schedule

| SUN | MON | TUE | WED | THUR | FRI | SAT | TOTAL HRS PER WEEK |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

For a flex schedule- please mark any regular days off as "off." Fill in other days as best you can, include earliest time in/latest time off.

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 Boulder County at the address or number at the bottom of page.

I confirm that the above information is complete and accurate:

_____ _____ _____

Printed Name of Employer/Supervisor Title Phone Number

_____ _____

Signature of Employer/Supervisor Date


# AUTHORIZATION FOR RELEASE OF INFORMATION

The Employer listed on this form is herewith authorized to release such information as is required by the aforementioned County Department of Human Services, which is an agent of the State Department of Human Services.

This authorization is granted on in connection with its use in administration of the CCAP, Colorado Child Care Assistance Program and for no other purpose. It shall continue in effect until such time as I state in writing to the aforementioned named County Department of Human Services that it is no longer valid.

I understand that it is mandatory to give my consent to obtain necessary information and failure to do so may result in the denial or termination of assistance.

CCAP Client Signature: _____

Date:_____

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