



## **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
FGP 265%	\$3,807.17	\$4,796.50	\$5,785.83	\$6,775.17	\$7,764.50	\$8,753.83

**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](mailto:imaging@bouldercounty.org)  
[www.bouldercountyccap.org](http://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? Are there other Adult Caretaker(s) in the household?			<input type="checkbox"/> Yes <input type="checkbox"/> No <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? <b>Please complete if applicable.</b>	<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:		
<b>Do you or anyone else in your household receive benefits from or participate in any of the following programs?</b>				<b>If no, would you like to receive more information?</b>	
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
<b>ACTIVITY: Check all that apply to this individual</b>				
<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
<b>ACTIVITY: Check all that apply to this individual</b>				
<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 \_\_\_\_\_



<b>Section 5: Primary Caretaker Work/Self-Employment Income</b>							
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			\$

<b>Section 6: Additional Adult Caretaker/Spouse Work/Self-Employment Income</b>							
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			\$

<b>Section 7: Court Ordered Child Support Paid Out</b>			
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
		\$	
		\$	

<b>Section 8: Child Support Ordered and/or Received</b>					
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.

<b>Individual Name:</b>	Effective Begin Date:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
<b>Other Income Types:</b> 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
<b>Assets:</b> 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: \$ _____
<b>Individual Name:</b>	Effective Begin Date:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
<b>Other Income Types:</b> 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
<b>Assets:</b> 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
<b>MY SCHEDULE</b>							
Work/Job Search							
Training/School							
<b>2ND ADULT CARETAKER</b>	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									

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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: \_\_\_\_\_

## LOW-INCOME CHILD CARE CLIENT RESPONSIBILITIES AGREEMENT

As a recipient of Colorado Child Care Assistance Program (CCCAP) Benefits, I agree to the following:

1. To notify my child care worker in writing within ten (10) calendar-days if my total household income exceeds 85% of the State Median Income (SMI) 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. Income amounts by household size can be found at [www.coloradoofficeofearlychildhood.com](http://www.coloradoofficeofearlychildhood.com).
2. To complete the re-determination process, including providing a complete re-determination packet and all required verification, when it is due, in order to maintain my CCCAP benefits.
3. To provide my child care worker with a copy of my un-expired picture ID that has been taken in the past ten (10) years issued by a school or U.S. federal or state governmental agency if I am declaring the identity of my child(ren) due to the child(ren) not having identification as part of the application or at re-determination if it was not previously received by my child care worker.
4. I agree to provide my child care worker with immunization records for my child(ren) if they are not yet school-age and care is provided outside of my home by an unrelated, Qualified Exempt Child Care Provider.
5. To notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.
6. To cooperate with the Child Support Services office for any child that is receiving care and has an absent parent if my county requires cooperation with Child Support Services.
7. To use the State approved Attendance Tracking System (ATS) as designed to check my child(ren) in and out of child care on the days that my child(ren) attends child care. If my child care provider has a state approved ATS waiver, I will check my child(ren) in and out as instructed by my child care worker and/or provider.
8. To not share my Attendance Tracking System Personal Identification Number (PIN) with my child care provider or any other individual and to notify my child care worker if my child care provider asks for this information.
9. To pay the parent fee listed on my child care authorization notice to my child care provider in the month that care is received.
10. If my CCCAP case closes and less than thirty (30) days have passed from date of closure before I have provided the verification needed to correct the reason for closure, services may resume as of the date the verification was received by the county. I also understand that I would be responsible for payment during the gap in service.

As a recipient of CCCAP benefits, I acknowledge the following:

1. If myself or any teen parent or adult caretaker on my child care case 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.
2. If child care is provided for an employment or self-employment activity then the taxable gross wages divided by the number of hours worked must equal at least the current federal minimum wage in order to continue receiving child care. If a self-employment endeavor is less than twelve (12) months old and I am not making minimum wage, I will communicate this to my child care worker so that I may utilize the Self-Employment Launch Period.
3. My parent fee is based on countable household income, household size and number of children in care and is subject to change. I will be noticed of my new parent fee at the time of application or re-determination; or, when a reduction/increase of household parent fee occurs.
4. If I do not pay my parent fee or make acceptable payment arrangements with my child care provider, I will lose my child care benefits at re-determination and will not be able to receive child care assistance with another child care provider and/or through any other county.
5. If myself or another caretaker on my child care case is found to have intentionally given false information by deed or omission, my child care household 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.

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  
4<sup>th</sup> 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](mailto:Imaging@bouldercounty.org)





**BOULDER CCAP CHILD CARE REQUEST FORM**

CCAP Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Child Care Needed:

	Child #1	Child #2	Child #3
Child name			
CARE needed	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
School Aged:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Type of care	FT <input type="checkbox"/> PT <input type="checkbox"/>	FT <input type="checkbox"/> PT <input type="checkbox"/>	FT <input type="checkbox"/> PT <input type="checkbox"/>
School Aged only:	BEFORE ONLY <input type="checkbox"/> AFTER ONLY <input type="checkbox"/> B/A <input type="checkbox"/> Full time NON-SCHOOL days <input type="checkbox"/> FT SUMMER <input type="checkbox"/>	BEFORE ONLY <input type="checkbox"/> AFTER ONLY <input type="checkbox"/> B/A <input type="checkbox"/> Full time NON-SCHOOL days <input type="checkbox"/> FT SUMMER <input type="checkbox"/>	BEFORE ONLY <input type="checkbox"/> AFTER ONLY <input type="checkbox"/> B/A <input type="checkbox"/> Full time NON-SCHOOL days <input type="checkbox"/> FT SUMMER <input type="checkbox"/>

Child #1 Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

CCAP Provider Name: \_\_\_\_\_ License Number: \_\_\_\_\_

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

This is a change in child care, please end date care at \_\_\_\_\_ as of \_\_\_\_\_

Child #2 Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

CCAP Provider Name: \_\_\_\_\_ License Number: \_\_\_\_\_

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

This is a change in child care, please end date care at \_\_\_\_\_ as of \_\_\_\_\_

Child #3 Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

CCAP Provider Name: \_\_\_\_\_ License Number: \_\_\_\_\_

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

This is a change in child care, please end date care at \_\_\_\_\_ as of \_\_\_\_\_

**PLEASE COMPLETE ADDITIONAL FORMS FOR ANY ADDITIONAL CHILDREN NEEDING CARE**

**3460 N. Broadway, Boulder, CO. 80304 OR 515 Coffman St., Longmont, CO 80501** E-mail: [imaging@bouldercounty.org](mailto:imaging@bouldercounty.org) call: 303.441.1000

# Boulder County CCAP EMPLOYMENT/INCOME VERIFICATION

## Form must be completed by employer

**CCAP Client Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Name of Business:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**City/State/Zip**

**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 seasonal employment?**  Yes/No. If yes, give dates \_\_\_\_\_

**Is employee expected to return to job?**  Yes/No. If yes, give date \_\_\_\_\_

**Is this temporary employment?**  Yes/No. If yes, give end date \_\_\_\_\_

### **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:**  all that apply: **M T W TH F ST SN**

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**



Boulder County Child Care Assistance Program (CCAP)  
 515 Coffman Street ~ Longmont CO 80501  
 3460 N Broadway ~ Boulder CO 80304  
 Phone: 303.441.1000  
 Imaging FAX: 303 441 1523  
 Imaging Email: [Imaging@bouldercounty.org](mailto:Imaging@bouldercounty.org)