

**COLORADO DEPARTMENT OF HUMAN SERVICES
 COLORADO CHILD CARE ASSISTANCE PROGRAM
 (CCCAP)
 RE-DETERMINATION OF ELIGIBILITY FORM**

You received this form so the County Department of Social/Human Services can update your eligibility for child care assistance. Please note that failure to complete a re-determination and to supply required documentation will result in the discontinuation of your child care benefits.

Please complete and return this form as soon as you receive it. If we do not receive this form and all required verification by _____ your CCCAP case will close and child care assistance will no longer be authorized as of _____ [Volume 3, Section 3.905.4].

Section 1:

Date: _____

Primary Adult Primary Caretaker Name: _____ Case #: _____

Residence Address: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact Name _____ Phone _____

Has your address changed? _____ Yes _____ No

If Yes, your new residence address is: _____

Do any of the following apply to your current living situation?	<input type="checkbox"/> Living in hotel or motel	<input type="checkbox"/> Living in camp ground	<input type="checkbox"/> Living in shelter	<input type="checkbox"/> Living in substandard housing such as car, park, etc.
	<input type="checkbox"/> Have a temporary living situation (please explain):			Date living situation began: ____/____/____ Anticipated end date: ____/____/____

Section 2:

EMPLOYMENT (include the last thirty (30) days of pay stubs for verification)

Primary adult caretaker's name: _____

1. Are you working?

____ Yes If Yes, where? _____ Phone _____
 How often paid? _____
____ No If No, when did you stop working (date)? _____

2. Do you have a second job?

____ Yes If Yes, where? _____ Phone _____
 How often paid? _____
____ No

3. Do you have a new job? (*Attach employment verification letter from employer*)

____ Yes If Yes, fill in the following Start Date _____
____ No Employer's Name _____ Phone _____
 Is this job in addition to the old job? Yes ____ No ____

4. Are there two adult caretakers in your home? (If you are a teen parent do not include your parents)

____ Yes ____ No **If Yes, answer questions 5 - 7**

Second adult caretaker's name: _____

5. Is he/she working?

____ Yes If Yes, where? _____ Phone _____
 How often paid? _____
____ No If no, when did you he/she stop working (date)? _____

6. Does he/she have a second job?

____ Yes If Yes, where? _____ Phone _____
 How often are you paid? _____
____ No

7. Does he/she have a new job? (*Attach employment verification letter from employer*)

____ Yes If Yes, fill in the following: Start Date _____
____ No Employer's Name _____ Phone _____
 Is this job in addition to the old job? Yes ____ No ____

Section 3:

 EDUCATION/TRAINING

Primary adult caretaker's name: _____

8. Are you in training? ___ Yes ___ No Where? _____
Are you in school? ___ Yes ___ No Where? _____

Second adult caretaker's name (if applicable): _____

9. Are you in training? ___ Yes ___ No Where? _____
Are you in school? ___ Yes ___ No Where? _____

Section 4:

 JOB SEARCH/DISABILITY

Primary adult caretaker name: _____

10. Are you looking for a job? ___ Yes ___ No If yes, start date? _____
Are you disabled? ___ Yes ___ No If yes, start date? _____
If yes, is the disability ___ permanent or ___ temporary?
If temporary, end date? _____
Are you on maternity leave? ___ Yes ___ No If yes, start date? _____
If yes, expected end date? _____

Secondary adult caretaker name (If applicable): _____

11. Is he/she looking for a job? ___ Yes ___ No If yes, start date? _____
Is he/she disabled? ___ Yes ___ No If yes, start date? _____
If yes, is the disability ___ permanent or ___ temporary?
If temporary, end date? _____
Is he/she on maternity leave? ___ Yes ___ No If yes, start date? _____
If yes, expected end date? _____

Section 5:

 HOUSEHOLD INFORMATION

List ALL people in your household:

Last Name, First Name, Middle Initial	How related to you?	Gender M/F	Date of Birth	Children's Immunization information: (codes below)
	SELF			

Immunization record codes: IM: Child Immunized ME: Medical Exemption RE: Religious Exemption OT: Other (explain)

Are any of the people listed above new to your household*? ____ Yes ____ No

If yes, complete the following information:

Newly added adults (If applicable) use additional paper if necessary and include all requested information

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Military Status	Marital Status (see codes below)	Hispanic or Latino (Y/N)	Race(s) List all that apply, (see codes below)
			<input type="checkbox"/> Active Military (serving full time) <input type="checkbox"/> Military Reserves <input type="checkbox"/> National Guard			
			<input type="checkbox"/> Active Military (serving full time) <input type="checkbox"/> Military Reserves <input type="checkbox"/> National Guard			

Race codes (use all that apply): **A**-Asian, **B**-Black/African American, **H**- Hispanic, **I**- American Indian/Alaska Native, **P**-Native Hawaiian/ Other Pacific Islander, **W**-White

Marital Status Codes: **D**-Divorced, **M**-Married, **S**-Single, **P**-Separated, **W**-Widowed

Newly added dependents/children (If applicable)

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child*? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information (codes below)
If this 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 this 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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Name of Parent(s) outside of household who may have duty for child support:
Last: _____ **First:** _____

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information (codes below)

If this 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 this 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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Name of Parent(s) outside of household who may have duty for child support:
Last: _____ **First:** _____

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information (codes below)

If this 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 this 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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Name of Parent(s) outside of household who may have duty for child support:
Last: _____ **First:** _____

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information (codes below)

If this 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 this 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
Name of Parent(s) outside of household who may have duty for child support: Last: _____ First: _____								
Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information (codes below)
If this 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 this 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
Name of Parent(s) outside of household who may have duty for child support: Last: _____ First: _____								
Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information (codes below)
If this 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 this 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
Name of Parent(s) outside of household who may have duty for child support: Last: _____ First: _____								

Race codes (use all that apply): **A**-Asian, **B**-Black/African American, **H**- Hispanic **I**: American Indian/Alaska Native **P**-Native Hawaiian/ Other Pacific Islander, **W**-White

Immunization record codes **IM**: Child Immunized **ME**: Medical Exemption **RE**: Religious Exemption **OT**: Other (explain)

Are any of the children listed above not U.S. citizens? ___ Yes ___ No If yes, please provide the following:

Child's name	Date of Birth	Alien Registration Information
		A
		A
		A
		A
		A
		A

Are any of the children listed above a part of a Joint Custody or Foster Custody Arrangement? ___ Yes ___ No If yes, please provide the following:

Child's name	Joint Custody or Foster Custody?	Date Moved into custody arrangement
	<input type="checkbox"/> Joint Custody <input type="checkbox"/> Foster Custody	
	<input type="checkbox"/> Joint Custody <input type="checkbox"/> Foster Custody	
	<input type="checkbox"/> Joint Custody <input type="checkbox"/> Foster Custody	
	<input type="checkbox"/> Joint Custody <input type="checkbox"/> Foster Custody	
	<input type="checkbox"/> Joint Custody <input type="checkbox"/> Foster Custody	
	<input type="checkbox"/> Joint Custody <input type="checkbox"/> Foster Custody	

Has anyone left your Household ___ Yes ___ No If yes, please provide the following:

Name	Date left	Reason for Leaving

Section 6:

Other Benefit Program 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?	
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 7:

EMPLOYMENT OR EDUCATION/TRAINING SCHEDULE(S)

Please fill in your employment or education/training schedule. If there are two adult caretakers in your household, fill in schedules for both adult caretakers. If you have more than one job, please be sure to include schedules for all employment

Example:	<i>Mon.</i> <i>(am/pm)</i>	<i>Tues.</i> <i>(am/pm)</i>	<i>Weds.</i> <i>(am/pm)</i>	<i>Thurs.</i> <i>(am/pm)</i>	<i>Fri.</i> <i>(am/pm)</i>	<i>Sat.</i>	<i>Sun.</i>
Schedule:	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	0	0
Hours:	9	7	9	7	9	0	0
My Schedule	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Work							
# Hours							
Education/Training							
# Hours							
2nd Adult Caretaker	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Work							
# Hours							
Education/ Training							
# Hours							

If your schedule varies please explain:

Section 8:

CHILDREN'S SCHEDULE(S)

Please fill in each child's schedule. Please indicate when you plan to have your child in care each day for each provider used (if more than one). Note that care will be approved based on eligibility and please attach a copy of each school-aged child's school calendar/schedule.

Child's Name:			Effective Begin Date:			Effective End Date:	
Provider Name and License #:							
Provider Address:							
Example:	<i>Mon.</i> <i>(am/pm)</i>	<i>Tues.</i> <i>(am/pm)</i>	<i>Weds.</i> <i>(am/pm)</i>	<i>Thurs.</i> <i>(am/pm)</i>	<i>Fri.</i> <i>(am/pm)</i>	<i>Sat.</i>	<i>Sun.</i>
Schedule:	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	0	0
Hours:	9	7	9	7	9	0	0
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule							
# Hours							
<p>Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what is their enrollment start date and end date?</p> <p>Start: ___ / ___ / _____ End: ___ / ___ / _____</p>							

CHILDREN'S SCHEDULE(S)

Please fill in each child's schedule. Please indicate when you plan to have your child in care each day for each provider used (if more than one). Note that care will be approved based on eligibility and please attach a copy of each school-aged child's school calendar/schedule.

Child's Name:	Effective Begin Date:	Effective End Date:
Provider Name and License #:		
Provider Address:		

Example:	<i>Mon.</i> <i>(am/pm)</i>	<i>Tues.</i> <i>(am/pm)</i>	<i>Weds.</i> <i>(am/pm)</i>	<i>Thurs.</i> <i>(am/pm)</i>	<i>Fri.</i> <i>(am/pm)</i>	<i>Sat.</i>	<i>Sun.</i>
Schedule:	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	0	0
Hours:	9	7	9	7	9	0	0
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule							
# Hours							

Is this child enrolled in a Head Start/Early Head Start Program? Yes No

If yes, what is their enrollment start date and end date?

Start: ___/___/_____ End: ___/___/_____

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILD SCHEDULES.

Page _____ of _____

Section 9:

INCOME QUESTIONS: List ALL income. If there is no income enter a zero.

Fill in your total family income per month:

Income Type	My Income	2nd Adult caretaker Income	Income Type	My Income	2nd Adult caretaker Income
Wages (before taxes)	\$	\$	Social Security survivor's benefits, permanent disability insurance payments	\$	\$
Self-employed income	\$	\$	Lease bonuses & royalties	\$	\$
Tips or ____% Commission	\$	\$	Military allotments	\$	\$
Child Support	\$	\$	Strike benefits	\$	\$
Alimony Payment	\$	\$	Dividends, interest, income from estates or trusts, net rental income, royalties	\$	\$
Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	\$	\$	Retirement and pension payments (Veteran's, Social Security pensions)	\$	\$
Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	\$	\$	Unemployment insurance	\$	\$
Worker's compensation	\$	\$	Other income	\$	\$

	TOTAL INCOME	\$	\$
	TOTAL FAMILY INCOME	\$	

OTHER INCOME (If applicable) Do you or anyone in your household receive any of the following income? If Yes, please complete the table below.

1. Housing voucher or cash assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Food stamp assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Refugee cash assistance or medical assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No
			No, I would like to apply		
4. Colorado Works/ TANF cash assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Supplemental Security Income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Low-income energy assistance (LEAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Old age pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Americorp Income	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Name of person receiving income	Type of income (use number from above)	How often received? (Monthly, weekly, etc.)

Other changes or comments you want to make: _____

Authorization to Supply Information

I hereby authorize the County Department of Social 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 child care 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 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 child care 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

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 found at 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.

YOU MUST READ AND SIGN THIS PAGE

You must submit the following documentation with this form:

IF YOU ARE WORKING YOUR NEED TO INCLUDE:

- For self-employed persons, a business ledger and copies of your total business earnings, your business expenditures for the last thirty (30) days, and your expected work schedule. (Please be aware that you must make a profit and you must meet the current Federal Minimum wage to remain eligible.
- Income verification and verification of the work schedule. You must attach copies of all household members' **pay stubs from the last thirty (30) days**. Please be aware that you must meet the current Federal Minimum wage to remain eligible.

If you just started a new job, you must provide a completed copy of the employment verification letter including: your start date, your wages, your schedule, number of hours/days you work per week, how often you will be paid, and the date of your first paycheck.

If you lose your job and need child care assistance while looking for work, Job Search Child Care is available on a LIMITED basis and you must have prior approval to use child care services for Job Search.

IF YOU ARE REQUESTING CARE FOR EDUCATION/TRAINING, YOU NEED TO INCLUDE:

A letter from your education/training institution which

1. verifies that you are enrolled and making satisfactory progress.
2. Identifies the program you are enrolled in, and
3. Identifies when you are expected to complete the program.
4. Start and end dates of quarter, semester, or session;
5. Days/time of class and
6. Number of credits.

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.

Completion Checklist Did you:					
	Complete redetermination		Attach required pay stubs		Attach employment verification letter (if new employment)
	Sign and date redetermination		Attach all training information		Attach verification of any other income
	Attach work or education/ training schedule		Attach all education information		

I certify that the information on this form is correct, to the best of my knowledge. I understand that failure to report 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.

Primary Adult Caretaker Signature	Daytime Phone	Date
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Other Adult Caretaker Signature	Daytime Phone	Date
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IMPORTANT REMINDERS:

A person found to have intentionally given false information by deed or omission cannot get child care assistance in Colorado 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.

You must report changes to income where the total income exceeds eighty-five per cent (85%) of the State Median Income, in writing, within ten (10) calendar days of the change. You must also report if you are no longer in your eligible activity, in writing, within four (4) calendar weeks.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social/human services.

Until you are approved for the Child Care Assistance Program you are responsible for the cost of child care. Please ask your eligibility worker for details.

After you are approved for the Child Care Assistance Program you are responsible for payment of Parental Fees (if applicable) to your Provider. Please ask your eligibility worker for details.

To remain eligible for the Child Care Assistance Program you are responsible for providing all required information to complete your re-determination. Please ask your eligibility worker for details.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social/human services.

Until you are re-determined as eligible for the Child Care Assistance Program you are responsible for the cost of child care.

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



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 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