For CCCAP Staff to Complete:		
Application Received Date:	**Pre-Eligibility: Yes ☐ No ☐** **Determined by: Provider ☐ County ☐**	**Case Number:**

Application for Colorado Child Care Assistance Program (CCCAP)

Definitions:

- **You** = The parent or primary guardian completing the application.
- **Primary Guardian** = An adult, not the parent, legally responsible for caring for a child.
- **Teen Parents** = Parent under twenty-one (21) years of age who has physical custody of their child(ren) for the period that care is requested and is in an eligible activity such as attending junior high/middle school, high school, GED program, vocational/technical training activity, employment, self-employment, or job search.
- **Additional Guardian/Spouse** = A person who lives in your house that cares for your children and/or provides financial assistance and support. This is a person who is assuming the parent obligations for a minor, including protecting their rights and/or a person who is standing in the role of the parent of a minor without having gone through the formal adoption process.

Instructions:

- **This application must be submitted by the parent or primary guardian of the children needing child care.**
- **Completing this application does not guarantee child care assistance.**
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please address each section and 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.

If you have questions about how to complete this form, please contact your county CCCAP office.

Section 1: Your Household Information (REQUIRED)

Today's Date: ____/____/_____	Are you the **parent** or **primary guardian** of the child(ren) for whom you are applying? ☐Parent ☐Primary Guardian	Is there an **Additional Guardian/Spouse** in the household? ☐Yes ☐No

Your Last Name:	Your First Name:	Your Middle Initial:

Do any of the following describe where you live?

☐Living in hotel or motel	☐Living in campground	☐Living in shelter	☐Living in someone else's home due to housing loss, economic struggles, etc.	☐Living in substandard housing such as car, park, abandoned building, etc.	☐Other temporary living situation (please explain):	☐None apply

Date living situation began: ____/_____/_____

Anticipated end date (if known): ____/_____/_____

Your Address:			Mailing Address: ☐Same as your address?		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Contact Information: *Complete at least one*	Your Email Address (**required**):		Primary Phone: ( ) Type:☐Home ☐Cell ☐Voice Msg.☐Work	Secondary Phone: ( ) Type:☐Home ☐Cell ☐Voice Msg.☐Work	
Preferred Contact Method: ☐Phone ☐Email ☐Mail					
Preferred language spoken in the home:					

There are other programs that can benefit you and your family...

So that we can connect you to those programs, please select one of the three options below for each program: I participate; I'd like to learn more; or I am not interested.
If you select that you would like to learn more, you will be connected to those programs to complete their referral or application processes to see if you qualify.

Head Start/Early Head Start Education Programs: free, quality education for children 0 to 5 years old (***not available in all communities***).	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Early Intervention Colorado: developmental supports available at no cost for children birth up to 3 years old	☐I participate. ☐I'd like to learn more because I am concerned about my birth up to 3-year-old child's development. ☐I'm not interested.
Preschool Special Education: education supports available at no cost for 3- to 5-year-olds	☐I participate. ☐I'd like to learn more because I am concerned about my 3- to 5-year-old child's development. ☐I'm not interested.
Colorado Works/Temporary Assistance for Needy Families (TANF) Cash Assistance: cash assistance for those who qualify	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Food Assistance (SNAP): assistance buying food	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Women, Infants and Children (WIC) Food and Nutrition Program: food, nutrition, and breastfeeding supports for you and your 0-5-year-old child(ren)	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Medicaid/CHP+ Health Insurance Assistance: health coverage for those who qualify.	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Housing Choice Voucher or cash assistance: assistance paying my rent or utilities	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Low-Income Energy Assistance (LEAP): assistance paying my heating bill	☐I participate. ☐I'd like to learn more. ☐I'm not interested.
Refugee Medical Assistance: medical assistance for refugees	☐I participate. ☐I'd like to learn more. ☐I'm not interested.

Section 2: Your Information (REQUIRED unless otherwise indicated)

Your Social Security Number: _____-____-_____ **(optional)**	Your Date of Birth (MM/DD/YYYY): ____/____/_____	Your Gender: ☐Male ☐Female

Race **(optional, mark all that apply):**	☐American Indian or Alaskan Native		☐Native Hawaiian or Pacific Islander		Ethnicity (optional): ☐Hispanic ☐Non-Hispanic
	☐Asian	☐Black	☐White	☐Other	

Highest Grade Completed:	☐Less Than High School/High School Equivalency	☐High School/High School Equivalency	☐Associate's Degree	☐Bachelor's Degree
	☐Master's Degree	☐Ph.D./Doctorate	☐Unknown	☐Other _____

Marital Status:	☐Married, Living w/Spouse	☐Married, Not Living w/Spouse (voluntarily)	☐Married, Not Living w/Spouse (involuntarily)	
	☐Significant Other	☐Single – Never Married	☐Widowed/Widower	☐Divorced

QUALIFYING ACTIVITY: Check all that apply to you			
☐Employed	☐Self-Employed	☐Job Search	☐Post-Secondary School Student
☐Training/Education	☐English as a Second Language Student	☐GED/High School Equivalency Student	☐Middle / Jr. High Student
☐Disabled	☐National Guard	☐Military Reserves	☐Active Military (serving full time)

Section 3: Additional Guardian/Spouse's Information

REQUIRED: Do you have an additional guardian/spouse? ☐**Yes** ☐**No**

If YES, you're required to complete the following table unless otherwise indicated.
If NO, skip to Section 4.

Guardian/Spouse Last Name:	Guardian/Spouse First Name:	Guardian/Spouse Middle Initial:

Social Security Number **(optional)**: _____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: ☐Male ☐Female	Relationship to You:

*Guardian/Spouse Email Address **(optional):**

Race **(optional, mark all that apply)**:	☐American Indian or Alaskan Native		☐Native Hawaiian or Pacific Islander		Ethnicity **(optional)**: ☐Hispanic ☐Non-Hispanic
	☐Asian	☐Black	☐White	☐Other	

Highest Grade Completed:	☐Less Than High School/High School Equivalency	☐High School/High School Equivalency	☐Associate's Degree	☐Bachelor's Degree
	☐Master's Degree	☐Ph.D./Doctorate	☐Unknown	☐Other _____

Marital Status:	☐Married, Living w/Spouse	☐Married, Not Living w/Spouse **(voluntarily)**	☐Married, Not Living w/Spouse **(involuntarily)**	
	☐Significant Other	☐Single – Never Married	☐Widowed/Widower	☐Divorced

QUALIFYING ACTIVITY: Check all that apply to your Additional Guardian/Spouse			
☐Employed	☐Self-Employed	☐Job Search	☐Post-Secondary School Student
☐Training/Education	☐English as a Second Language Student	☐GED/High School Equivalency Student	☐Middle / Jr. High Student
☐Disabled	☐National Guard	☐Military Reserves	☐Active Military (serving full time)

Section 4: Child(ren)'s Information – (REQUIRED unless otherwise indicated)

Complete this section for <u>every</u> child in your home

***Please include all children in your home regardless of whether or not you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number **(Optional)**:	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to You:
_____-____-_____	____/____/_____	☐Male ☐Female	

Citizenship Status:	Race **(optional, mark all that apply)**:				Ethnicity **(optional)**:
☐Citizen	☐American Indian or Alaskan Native		☐Native Hawaiian or Pacific Islander		☐Hispanic
☐Non-citizen	☐Asian	☐Black	☐White	☐Other	☐Non-Hispanic
☐Qualified Alien[1]					

Is this a child who is part of a Joint Custody agreement or another case?	☐Yes ☐No	Are you requesting care for this child?	☐Yes ☐No

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines):	Does this child have a disability or have additional care needs?
☐Yes, Immunized ☐No, In Process ☐No, Non-medical Exemption ☐No, Medical Exemption ☐Other	☐Yes ☐No

Section 4 Cont'd: Child(ren)'s Information - Complete this section for <u>every</u> child in your home

***Please include all children in your home regardless of whether you are requesting care for them.**

[1] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number **(Optional)**: _____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: ☐Male ☐Female	Relationship to You:

Citizenship Status: ☐Citizen ☐Non-citizen ☐Qualified Alien[2]	Race **(optional, mark all that apply)**:	☐American Indian or Alaskan Native	☐Asian	☐Black	☐Native Hawaiian or Pacific Islander	☐White	☐Other	Ethnicity **(optional)**: ☐Hispanic ☐Non-Hispanic

Is this a child who is part of a Joint Custody agreement or another case?	☐Yes ☐No	Are you requesting care for this child?	☐Yes ☐No

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines): ☐Yes, Immunized ☐No, In Process ☐No, Non-medical Exemption ☐No, Medical Exemption ☐Other	Does this child have a disability or have additional care needs? ☐Yes ☐No

Section 4 Cont'd: Child(ren)'s Information - Complete this section for <u>every</u> child in your home
***Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number **(Optional)**: _____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: ☐Male ☐Female	Relationship to You:

Citizenship Status: ☐Citizen ☐Non-citizen ☐Qualified Alien[3]	Race **(optional, mark all that apply)**:	☐American Indian or Alaskan Native	☐Asian	☐Black	☐Native Hawaiian or Pacific Islander	☐White	☐Other	Ethnicity **(optional)**: ☐Hispanic ☐Non-Hispanic

Is this a child who is part of a Joint Custody agreement or another case?	☐Yes ☐No	Are you requesting care for this child?	☐Yes ☐No

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines): ☐Yes, Immunized ☐No, In Process ☐No, Non-medical Exemption ☐No, Medical Exemption ☐Other	Does this child have a disability or have additional care needs? ☐Yes ☐No

[2] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.
[3] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Section 4 Cont'd: Child(ren)'s Information - Complete this section for <u>every</u> child in your home
***Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number **(Optional)**:	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to You:
_____-____-_____	____/____/_____	☐Male ☐Female	

Citizenship Status:	Race **(optional, mark all that apply)**:				Ethnicity **(optional)**:
☐Citizen ☐Non-citizen ☐Qualified Alien[4]	☐American Indian or Alaskan Native		☐Native Hawaiian or Pacific Islander		☐Hispanic ☐Non-Hispanic
	☐Asian	☐Black	☐White	☐Other	

Is this a child who is part of a Joint Custody agreement or another case?	☐Yes ☐No	Are you requesting care for this child?	☐Yes ☐No

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines):	Does this child have a disability or have additional care needs?
☐Yes, Immunized ☐No, In Process ☐No, Non-medical Exemption ☐No, Medical Exemption ☐Other	☐Yes ☐No

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN
Page _____of _____

[4] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Section 5: Your Work/Self-Employment Income

REQUIRED: Do you have work or self-employment income? ☐**Yes** ☐**No**

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)
If NO, skip to Section 6.
Include the last thirty (30) days of pay stubs for verification; If the last 30 days does not represent your regular income, please submit additional pay stubs for an accurate eligibility determination.
Note: If any of your jobs started within the last 60 days, you may instead provide an employer letter that includes a start date, hourly wage or gross salary amount, hours worked per week, pay frequency, and employer contact information.

Employer or Business Name	Employer or Business Address and Telephone Number	Work/Self-Employment Start Date	Self-Employed (or 1099)	# of hours per week	How often paid	Total earnings per pay period (including tips & commissions) ***before taxes***
			☐No ☐Yes, as an LLC ☐Yes, as an S corp			$
			☐No ☐Yes, as an LLC ☐Yes, as an S corp			$

Section 6: Additional Guardian/Spouse Work/Self-Employment Income

REQUIRED: Does your additional guardian/spouse have work or self-employment income? ☐**Yes** ☐**No**

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)
If NO, skip to Section 7.
Include the last thirty (30) days of pay stubs for verification; If the last 30 days does not represent your regular income, please submit additional pay stubs for an accurate eligibility determination.
Note: If any of their jobs started within the last 60 days, you may instead provide an employer letter that includes a start date, hourly wage or gross salary amount, hours worked per week, pay frequency, and employer contact information.

Name of additional guardian/spouse						
Employer or Business Name	Employer or Business Address and Telephone Number	Work/Self-Employment Start Date	Self-Employed	# of hours per week	How Often paid	Total earnings per pay period (including tips & commissions) ***before taxes***
			☐No ☐Yes, as an LLC ☐Yes, as an S corp			$
			☐No ☐Yes, as an LLC ☐Yes, as an S corp			$

Section 7: Court Ordered Child Support Paid Out

REQUIRED: Do you or your additional guardian/spouse make child support payments for any child(ren)?
☐Yes ☐No

If YES, you're required to complete the following table: (VERIFICATION OF COURT ORDER AND PAYMENT IS REQUIRED.)
If NO, skip to Section 8.

Name of person making payment	Name of child	Amount paid	How often paid
		$	
		$	

Section 8: Child Support Received and/or Ordered

Your county may require you to apply for child support if you do not currently receive it. Talk to your CCCAP specialist for more information.

REQUIRED: Do you receive child support for any of your children? ☐Yes ☐No
REQUIRED: Has child support been ordered for any of your children? ☐Yes ☐No ☐Not sure

If YES to either, you're required to complete the following table:
If NO to both, skip to Section 9a.

Child Name(s)	Is child support received?	Is child support ordered?	Amount of Child Support Paid	How often paid	How is it paid? (Venmo, cash, check, family support registry (FSR), etc.)	Name of non-custodial parent
	☐Yes ☐No	☐Yes ☐No	$			
	☐Yes ☐No	☐Yes ☐No	$			

Section 9a: Other Income

You must report <u>all</u> income coming into your household so your CCCAP specialist can determine if it is countable when determining your eligibility.

Scan the list of "other income types" below.

REQUIRED: Do you or any household members have other types of income? ☐Yes ☐No
If you don't see your income type included in the list below, write it in in the "other" spaces at the bottom.

If YES, you're required to complete the information below for <u>each person</u> in your household that has other income:
If NO, skip to section 9b.

Your Other Income:

Your Other Income Type	Mark if Receiving	Begin Date	Expected End Date	Amount	How often is the income amount received? (weekly, monthly, annually, etc.)
Alimony/Maintenance	☐				
Cash Contributions	☐				
Gifts	☐				

"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	☐				
Social Security (Survivor's, Disability, Retirement)	☐				
Supplemental Security Income (SSI)	☐				
Unemployment Compensation	☐				
Veteran's Benefits	☐				
Other Income (List Type):					
Other Income (List Type):					

Additional Guardian/Spouse's Other Income:

Additional Guardian/Spouse Other Income Type	**Mark if Receiving**	**Begin Date**	**End Date**	**Amount**	**How often is the income amount received? (weekly, monthly, annually, etc.)**
Alimony/Maintenance	☐				
Cash Contributions	☐				
Gifts	☐				
"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	☐				
Social Security (Survivor's, Disability, Retirement)	☐				
Supplemental Security Income (SSI)	☐				
Unemployment Compensation	☐				
Veteran's Benefits	☐				
Other Income (List Type):					
Other Income (List Type):					

Child's Other Income **(Don't include child support covered in Sec. 8)** — Child's Name**:**

Child(ren)'s Other Income Type	**Mark if Receiving**	**Begin Date**	**End Date**	**Amount**	**How often is the income amount received? (weekly, monthly, annually, etc.)**
Alimony/Maintenance	☐				
Cash Contributions	☐				
Gifts	☐				
"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	☐				
Social Security (Survivor's, Disability, Retirement)	☐				
Supplemental Security Income (SSI)	☐				
Unemployment Compensation	☐				
Veteran's Benefits	☐				
Other Income (List Type):					
Other Income (List Type):					

COPY THIS PAGE AS NEEDED FOR ADDITIONAL GUARDIAN/SPOUSE OR CHILDREN RECEIVING OTHER INCOME

Page _____of _____

Section 9b: Assets (resources, belongings, valuables, etc.)

If your countable assets are worth more than $1,000,000 then you may not be eligible for CCCAP.

REQUIRED: Do you or your additional guardian/spouse have any liquid resources? ☐**Yes** ☐**No**
Liquid resources are cash assets that may include (but are not limited to): cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.

If NO, answer the next question about non-liquid resources.
If YES, you're required to provide the amount of your liquid resources in dollars $_____

REQUIRED: Do you or your additional guardian/spouse have any non-liquid resources? ☐**Yes** ☐**No**
Non-liquid resources are non-cash assets that may include (but are not limited to): licensed/unlicensed automobile, RVs, real property, etc.

If NO, skip to Section 10.
If YES, you're required to provide the current dollar value of your non-liquid resources $_____

Section 10: Training/Education/Teen Parent Education Detail

Talk to your CCCAP specialist to learn about time limits on eligibility for CCCAP under this activity.

REQUIRED: Are you or your additional guardian/spouse participating in a training/education activity?
☐**Yes** ☐**No**

If YES, you're required to complete the following table: (VERIFICATION IS REQUIRED)
If NO, skip to Section 11.

Individual Name:	Effective Begin Date:		
Training/Education Institution:	Type of Training: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐Vocational or Trade School ☐Certificate Program ☐Post-Secondary Education (first bachelor's degree or less)	Anticipated Completion Date:	Number of Credits (if applicable)
Individual Name:	Effective Begin Date:		
Training/Education Institution:	Type of Training: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐Vocational or Trade School ☐Certificate Program ☐Post-Secondary Education (first bachelor's degree or less)	Anticipated Completion Date:	Number of Credits (if applicable)

Section 11: Disability Detail

REQUIRED: Are you or an additional guardian/spouse disabled? ☐**Yes** ☐**No**

If YES, you're required to complete the following table: (VERIFICATION IS REQUIRED)
If NO, skip to Section 12.

Name:	Disability Begin Date:

Disability Type: ☐Permanent ☐Temporary; Anticipated End Date:_____	Is this Individual able to take care of the child(ren)? ☐Yes ☐No	Physician Review Due Date **(if applicable)**:
Name:		Disability Begin Date:
Disability Type: ☐Permanent ☐Temporary; Anticipated End Date:_____	Is this Individual able to take care of the child(ren)? ☐Yes ☐No	Physician Review Due Date **(if applicable)**:

Section 12: Employment/Training/School/Job Search Schedule
Please fill in your expected schedule. If there is an additional guardian/spouse, fill in schedules for both. If you have more than one job please list your work schedule for both jobs.

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*
YOUR SCHEDULE	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							
ADDITIONAL GUARDIAN/SPOUSE SCHEDULE	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							

If your schedule varies please explain:

_____

_____

_____

Section 13: Children's Current Care Schedule (REQUIRED)

Please complete a row for each child needing care. Do not complete for children who do not need care. If there are changes to your child's care schedule you MUST inform your CCCAP specialist. If you need assistance identifying a provider, visit www.coloradoshines.com or call 877-338-2273.

Child Name	Child In School (k-8th grade)	Grade and School Of Attendance	Child's Schedule: Please indicate the anticipated number of hours of care needed per day. If you have a non-traditional schedule, list the exact times that care is needed. This information is necessary, so we know how many hours you need covered by CCCAP. Provider License #, or Provider Name, Address and Phone # where the child is enrolled	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	☐Yes ☐No									

Is this a new provider? (REQUIRED) ☐Yes ☐No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ☐Yes ☐No

If yes, you're required to provide an anticipated Start Date: Start:___/____/_____

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: ___/____/____

Child Name	Child In School (k-8th grade)	Grade and School Of Attendance	Provider License #, or Provider Name, Address and Phone # where the child is enrolled	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	☐Yes ☐No									

Is this a new provider? (REQUIRED) ☐Yes ☐No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ☐Yes ☐No

If yes, you're required to provide an anticipated Start Date: Start:___/____/_____

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: ___/____/____

Child Name	Child In School (k-8th grade)	Grade and School Of Attendance	Provider License #, or Provider Name, Address and Phone # where the child is enrolled	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	☐Yes ☐No									

Is this a new provider? (REQUIRED) ☐Yes ☐No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ☐Yes ☐No

If yes, you're required to provide an anticipated Start Date: Start:___/____/_____

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: ___/____/____

Child Name	Child In School (k-8th grade)	Grade and School Of Attendance	Provider License #, or Provider Name, Address and Phone # where the child is enrolled	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	☐Yes ☐No									

Is this a new provider? (REQUIRED) ☐Yes ☐No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ☐Yes ☐No

If yes, you're required to provide an anticipated Start Date: Start:___/____/_____

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: ___/____/____

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.

☒ Your Signature: _____ Date: _____

☒Signature of Additional Guardian/Spouse: _____ Date: _____

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.

☒ Your Signature: _____ Date: _____

☒Signature of Additional Guardian/Spouse:_____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.cdec.colorado.gov.

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. 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.

4. To notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.

5. 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.

6. 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.

7. 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.

8. To pay the parent fee listed on my child care authorization notice to my child care provider in the month that care is received.

9. If my CCCAP case closes and less than thirty (30) days have passed from the 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 additional guardian/spouse in 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 notified 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 an additional guardian/spouse in 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.

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
   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