



New Provider	□Change of Provider	□Schedule Change	□Re-determination/Application
CCAP Client's Name:			
Client Signature:		Date:	
Child 1 Name:		Start Date:	
CCAP Provider Name:		License Number	:
Provider Email/Phone #:			
Type of Care: FT □ PT □	Will this child attend UPK: YE	S $\Box$ NO $\Box$ How many hours	a week:
School Aged: YES□NO□	BEFORE ONLY 🗆 AFTER ONL	.Y 🗆 B/A 🗆 FT NON-SCHOOL I	DAYS 🗆 FT SUMMER 🗆
Child 1 Age:	Will this child attend kinderg	arten (public/private facility)	in August: YES 🗆 NO 🗆
School Name and District:			

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
CCAP Schedule (if all day)							
CCAP Morning Hours							
CCAP Afternoon Hours							
CCAP Early Release							
CCAP Non- school Days (breaks, holidays, or summer) Hours							
UPK Hours per Day							

If this is a change in childcare, please end date care at		as of			
		(Provider Name)	(Date)		
Child 2 Name:		Start Date:			
CCAP Provider Name:		License Numb	er:		
Provider Email/Phone #:					
Type of Care: FT $\Box$ PT $\Box$	Will this child attend U	JPK: YES 🗆 NO 🗆 How many hou	urs a week:		
School Aged: YES□NO□	BEFORE ONLY 🗆 AFTE	R ONLY 🗆 B/A 🗆 FT NON-SCHOO	DL DAYS 🗆 FT SUMMER 🗆		
Child 2 Age:	Will this child attend k	indergarten (public/private facili	ty) in August:YES 🗆 NO 🗆		
School Name and District:					





Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
CCAP Schedule (if all day)							
CCAP Morning Hours							
CCAP Afternoon Hours							
CCAP Early Release							
CCAP Non- school Days (breaks, holidays, or summer) Hours							
UPK Hours per Day							

If this is a change in childcare, please end date care at		as of
	(Provider Name)	(Date)
Child 3 Name:	Start Date:	
CCAP Provider Name:	License Numbe	r:

Provider Email/Phone #: \_\_\_\_\_

 Type of Care: FT 
 PT 
 Will this child attend UPK: YES 
 NO 
 How many hours a week: \_\_\_\_\_\_\_

School Aged: YES□ NO□

BEFORE ONLY  $\Box$  AFTER ONLY  $\Box$  B/A  $\Box$  FT NON-SCHOOL DAYS  $\Box$  FT SUMMER  $\Box$ \_\_\_\_\_ Will this child attend kindergarten (public/private facility) in August: YES  $\Box$  NO  $\Box$ 

Child 3 Age:\_\_\_\_\_

School Name and District:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
CCAP Schedule							
(if all day)							
CCAP Morning							
Hours							
CCAP Afternoon							
Hours							
CCAP Early							
Release							
CCAP Non-							
school Days							
(breaks,							
holidays, or							
summer) Hours							
UPK Hours per							
Day							

If this is a change in childcare, please end date care at \_\_\_\_\_as of \_\_\_\_as of \_\_\_\_\_as of \_\_\_\_as of \_\_\_\_as of \_\_\_\_\_as of \_\_\_\_as of \_\_\_as of \_\_\_\_as of \_\_\_as of \_\_\_as of \_\_\_as of \_\_\_as

(Provider Name)

(Date)

Adams County Department of Human Services Colorado Child Care Assistance Program 11860 Pecos St Westminster, CO 80234 Revised 6/2023

Phone: 720-523-2337 Fax 720-523-2201 Email: AdamsCCAP@adcogov.org





Child 4 Name:	Start Date:
CCAP Provider Name:	License Number:
Provider Email/Phone #:	
Type of Care: FT 🗆 PT 🗆	Will this child attend UPK: YES $\Box$ NO $\Box$ How many hours a week:
School Aged: YES□NO□	BEFORE ONLY $\Box$ AFTER ONLY $\Box$ B/A $\Box$ FT NON-SCHOOL DAYS $\Box$ FT SUMMER $\Box$
Child 4 Age:	Will this child attend kindergarten (public/private facility) in August: YES $\Box$ NO $\Box$
School Name and District:	

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
CCAP Schedule							
(if all day)							
CCAP Morning							
Hours							
CCAP Afternoon							
Hours							
CCAP Early							
Release							
CCAP Non-							
school Days							
(breaks,							
holidays, or							
summer) Hours							
UPK Hours per							
Day							

If this is a change in childcare, please end date care at		as of		
<u> </u>			<i>i</i>	

(Provider Name)

(Date)