

**\*COLORADO CHILD CARE ASSISTANCE PROGRAM Application Checklist**  
***\*Please use blue or black ink only when completing this application\*\****

In order for your Colorado Child Care Assistance Program (CCCAP) application to be processed, you *must* provide the following information in addition to the completed application. You may submit your application before providing this information.

<b>Pay stubs for the past month and an employer letter on company letterhead. This letter must include:</b>	
<ul style="list-style-type: none"> <li>▪ Name and address of the company;</li> <li>▪ Date you began working</li> <li>▪ Number of hours you work each week;</li> <li>▪ Schedule</li> </ul>	<ul style="list-style-type: none"> <li>▪ Amount you are paid per hour;</li> <li>▪ How often you are paid and on what day of the week (weekly, bi-weekly, twice a month, or monthly) e.g. Paid bi-weekly on Thursday</li> </ul>
<b>Verification of any unearned income, which would include:</b>	
<ul style="list-style-type: none"> <li>▪ Child support</li> <li>▪ Unemployment</li> <li>▪ Regular help from friends or relatives</li> <li>▪ Social Security</li> </ul>	<ul style="list-style-type: none"> <li>▪ Workman's Compensation</li> <li>▪ Any other monies received by your household that is not from employment</li> </ul>
<b>Verification of the Citizenship status of the children you are requesting care for.</b>	
<ul style="list-style-type: none"> <li>▪ Birth Certificate</li> <li>▪ Possession of a U.S. passport</li> <li>▪ Certificate of Naturalization</li> </ul>	<ul style="list-style-type: none"> <li>▪ Identification cards for U.S. citizens</li> <li>▪ A certificate of U.S. citizenship</li> <li>▪ Certificate of birth abroad of a citizen of the United States</li> </ul>
<b>Verification of Identity for Parent in the Household:</b>	
<ul style="list-style-type: none"> <li>▪ Official Picture Identification (original)</li> </ul>	
<b>Other</b>	
<ul style="list-style-type: none"> <li>▪ Parents must provide proof of county residency (i.e.: rent receipt/lease, mortgage statement, utility or other bill mailed no more than two months previously, voter registration, and automobile registration).</li> </ul> <p>If you are attending school or GED program, you are required to submit the following information:</p> <ul style="list-style-type: none"> <li>▪ School advisor's statement of completion date or graduation date</li> <li>▪ Copy of class schedule issued by your school</li> </ul>	

**For CCAP Income Guidelines please visit:**  
[coloradoofficeofearlychildhood.com](http://coloradoofficeofearlychildhood.com)  
 General Program Information/Questions:  
 (970) 498-6300

**Fort Collins Office**  
 1501 Blue Spruce Drive

**Loveland Office**  
 200 Peridot Avenue

**Estes Park**  
 1601 Brodie Avenue



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Application Received Date:	Pre-Eligibility: Yes <input type="checkbox"/> No <input type="checkbox"/>	Case Number:
	Determined by: Provider <input type="checkbox"/> County <input type="checkbox"/>	

## 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 \_\_\_\_\_

**Section 5: Primary Caretaker Work/Self-Employment Income**

Do you have Work or Self-Employment income?  Yes  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			\$

**Section 6: Additional Adult Caretaker/Spouse Work/Self-Employment Income**

Do you have Work or Self-Employment income?  Yes  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			\$

**Section 7: Court Ordered Child Support Paid Out**

Do you make child support payments for any child(ren)?  Yes  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
		\$	
		\$	

**Section 8: Child Support Ordered and/or Received**

Has child support been ordered and/or has it been received?  Yes  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:
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:
Name:		Effective Begin Date:	Effective End Date:
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:

**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:
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:	
Name:		Disability Begin Date:	Disability End Date:
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:	

**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: \_\_\_\_\_

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## CLIENT RESPONSIBILITIES AGREEMENT

1. I agree to notify my child care worker in writing within ten (10) days if my total household income exceeds 85% of the State Median Income (found on [www.coloradoofficeofearlychildhood.com](http://www.coloradoofficeofearlychildhood.com)) 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.
2. I agree that I must complete the redetermination process when it is due, including all required verification.
3. I agree that I must verify my eligible activity when there is a change in my eligible activity and at re-determination. (A schedule will be required if you are self-employed or when non-traditional care such as overnight, weekend, or evening care, is needed)
4. I agree to notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.
5. I agree to be responsible for resolving any problems I might have with my child care provider.
6. I agree to notify the County Department of Social/Human Services if I have any concerns about possible abuse or neglect of a child while in child care.
7. I understand that if any parent in my household 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.
8. I understand that if child care is provided for my employment or self-employment activity then the taxable gross wages divided by the number of hours I work must equal at least the current federal minimum wage in order to continue receiving child care.
9. I agree that if my county requires child support enforcement I will cooperate with the child support enforcement office for any child that is receiving care and has an absent parent.
10. I agree that I will use the State Attendance System as designed to check my child(ren) in and out of the child care facility.
11. I understand that a person found to have intentionally given false information by deed or omission 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.
12. PARENT FEE:
  - a. I agree to pay the parent fee listed on my child care authorization notice and that it is due to the provider in the month that care is received.
  - b. I understand that my parent fee is based on my income, household size and number of children in care and is subject to change upon receiving prior notice from the county.
  - c. I understand that if I do not pay this fee or make acceptable payment arrangements with my childcare provider, I will lose my child care benefits at re-determination and will not be able to receive assistance with another child care provider and/or through any other county.

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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.

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## 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

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# LARIMER COUNTY | Human Services | Child Care Assistance Program

1501 Blue Spruce Drive, Fort Collins, Colorado 80524, 970.498.6300, Fax 970.498.7987, Larimer.org/dhs/ccap, CCAP@co.larimer.co.us

RE: Employee: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_

Dear Employer:

In order to determine eligibility for the above named employee we need the following information. Your cooperation is appreciated, as Larimer County Human Services does not subscribe to any third-party verification systems. If you have questions about completing this form, please contact \_\_\_\_\_ at \_\_\_\_\_. Please return this form by: \_\_\_\_\_.

<input type="checkbox"/> Date Employment Started: _____	<input type="checkbox"/> Date Employment Ended: _____
<input type="checkbox"/> Approximate number of hours employee will be working per week (please do not put "varies"): _____	
<input type="checkbox"/> Hourly rate of pay: _____	
<input type="checkbox"/> How often is this employee paid (e.g. every Friday, the 5th & 20th, last working day of the month, every other Wednesday)? _____	
<input type="checkbox"/> What type of work does this employee do? _____	
<input type="checkbox"/> Average tips per pay period _____	Does this person receive tips in cash? _____
<input type="checkbox"/> How often are cash tips received (e.g. at the end of every shift, once a week, etc.)? _____	
<input type="checkbox"/> Does this person earn commissions? _____	If yes, when and in what amount? _____
<input type="checkbox"/> Does this person receive bonus pay? _____	If yes, when and in what amount? _____
<input type="checkbox"/> Is this temporary employment? _____	If yes, when will the job end? _____

<input type="checkbox"/> <b>Change in Schedule</b>	<b>Effective Date:</b> _____
<input type="checkbox"/> <b>Employee's Daily Work Schedule &amp; Availability:</b> <u><b>MUST BE FILLED OUT! Do not use "varies".</b></u>	
	<b>BEGINNING TIME</b> <b>ENDING TIME</b>
<b>MONDAY:</b>	<b>THURSDAY:</b>
<b>TUESDAY:</b>	<b>FRIDAY:</b>
<b>WEDNESDAY:</b>	<b>SATURDAY:</b>
	<b>SUNDAY:</b>
<input type="checkbox"/> <b>Approximately how many days per week is the employee expected to work?</b>	

Gross wages received, (including bonus pay, tips, vacation, etc.) for the month(s) of: \_\_\_\_\_

Date Check Received	Gross Amount	No. of Hours Worked	Other Income Received

\_\_\_\_\_  
 Name and title of person completing this form

\_\_\_\_\_  
 Company Name

\_\_\_\_\_  
 Signature of person completing this form

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Phone #



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# LARIMER COUNTY | Human Services | Child Care Assistance Program

1501 Blue Spruce Drive, Fort Collins, Colorado 80524, 970.498.6300, Larimer.org/dhs/ccap

**CCAP Tech:** \_\_\_\_\_

**HH Number:** \_\_\_\_\_

**CCAP Eligibility Date:** \_\_\_\_\_

## CCAP REFERRAL TO CHILD SUPPORT

**CUSTODIAL PARENT (CP):** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**PHONE NUMBERS:** \_\_\_\_\_

### CHILD(REN):

1. **Child's Name:** \_\_\_\_\_

**Child's DOB:** \_\_\_\_\_ **Child's SSN:** \_\_\_\_\_

**Absent Parent's Name:** \_\_\_\_\_

**Absent Parent's DOB:** \_\_\_\_\_ **Absent Parent's SSN:** \_\_\_\_\_

Are you paid support by the Absent Parent?  Yes  No

Is it court ordered?  Yes  No If yes, County & State of order: \_\_\_\_\_

Are there other possible father(s)?  Yes  No If yes, list names of other possible father(s):

\_\_\_\_\_  
\_\_\_\_\_

2. **Child's Name:** \_\_\_\_\_

**Child's DOB:** \_\_\_\_\_ **Child's SSN:** \_\_\_\_\_

**Absent Parent's Name:** \_\_\_\_\_

**Absent Parent's DOB:** \_\_\_\_\_ **Absent Parent's SSN:** \_\_\_\_\_

Are you paid support by the Absent Parent?  Yes  No

Is it court ordered?  Yes  No If yes, County & State of order: \_\_\_\_\_

Are there other possible father(s)?  Yes  No If yes, list names of other possible father(s):

\_\_\_\_\_  
\_\_\_\_\_



**CCAP REFERRAL TO CHILD SUPPORT, p2**

CUSTODIAL PARENT (CP): \_\_\_\_\_

3. Child's Name: \_\_\_\_\_  
Child's DOB: \_\_\_\_\_ Child's SSN: \_\_\_\_\_  
Absent Parent's Name: \_\_\_\_\_  
Absent Parent's DOB: \_\_\_\_\_ Absent Parent's SSN: \_\_\_\_\_  
Are you paid support by the Absent Parent? Yes No  
Is it court ordered? Yes No If yes, County & State of order: \_\_\_\_\_  
Are there other possible father(s)? Yes No If yes, list names of other possible father(s):  
\_\_\_\_\_  
\_\_\_\_\_

4. Child's Name: \_\_\_\_\_  
Child's DOB: \_\_\_\_\_ Child's SSN: \_\_\_\_\_  
Absent Parent's Name: \_\_\_\_\_  
Absent Parent's DOB: \_\_\_\_\_ Absent Parent's SSN: \_\_\_\_\_  
Are you paid support by the Absent Parent? Yes No  
Is it court ordered? Yes No If yes, County & State of order: \_\_\_\_\_  
Are there other possible father(s)? Yes No If yes, list names of other possible father(s):  
\_\_\_\_\_  
\_\_\_\_\_

5. Child's Name: \_\_\_\_\_  
Child's DOB: \_\_\_\_\_ Child's SSN: \_\_\_\_\_  
Absent Parent's Name: \_\_\_\_\_  
Absent Parent's DOB: \_\_\_\_\_ Absent Parent's SSN: \_\_\_\_\_  
Are you paid support by the Absent Parent? Yes No  
Is it court ordered? Yes No If yes, County & State of order: \_\_\_\_\_  
Are there other possible father(s)? Yes No If yes, list names of other possible father(s):  
\_\_\_\_\_  
\_\_\_\_\_

I understand that if I am receiving CCAP benefits I am required to cooperate with Child Support Enforcement (CSE) in establishing and enforcing a child support order against the absent parent.

The information provided above is true to the best of my knowledge.

\_\_\_\_\_  
Signature of Custodial Parent

\_\_\_\_\_  
Date

# UNRELATED INDIVIDUAL QUESTIONNAIRE

Participant Name: \_\_\_\_\_

HH# \_\_\_\_\_

Technician # \_\_\_\_\_

The Colorado Child Care Assistance Program (CCCAP) must determine if an unrelated adult living in your home acts as a parent to your child(ren) and provides financial support to you and your child(ren). Please answer the following questions.

**I. IS THERE ANYONE LIVING IN YOUR HOUSEHOLD WHO IS NOT RELATED TO YOU OR YOUR CHILDREN?**

**YES, Name of Individual: \_\_\_\_\_** *Please answer all questions in sections II, III and IV.*

**NO, Please skip ahead to section IV.**

**II. Financial Assistance:** Does the unrelated individual living in your home provide any of the following to you or your child(ren):  **YES**  **NO**

***Some examples of financial assistance:***

Routinely pays medical bills for any member of your family.

Provides health insurance for any member of your family.

Allows you to use their debit or credit cards.

Maintains a joint bank account with you or your child(ren).

Owns or is buying a motor vehicle jointly with you or your child(ren).

Owns/ is buying real estate, including your home, with you or your child(ren).

Pays 100% of the shelter and utility costs for you and your child(ren).

**III. Parenting:** Does the unrelated individual living in your home provide daily decision-making and guidance for your child(ren):  **YES**  **NO**

***Some examples of parenting:***

Routinely purchases clothing for your child(ren).

Pays fees for extracurricular activities or private school.

Decides your child(ren)'s future about schooling or religion.

Routinely disciplines your child(ren).

Routinely helps with homework or school projects.

Routinely attends child's school or extracurricular activities.

Is recognized by school, child care provider or doctor's office as being able to sign for services in your place.

Routinely make decisions about activities of daily living such as bedtime, clothing, going to friends, etc.

**IV. I attest that the above information is true and correct.**

\_\_\_\_\_  
**Applicant/Participant Signature**

\_\_\_\_\_  
**Date**

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# Voter Registration Choice Form

## Instructions

Please read the following information and complete and sign the form below. This agency will keep the form for its records.

## Important Notice

You may file a complaint with the Colorado Secretary of State if you believe that someone has interfered with your right to:

- register or decline to register to vote,
- privacy in deciding whether to register or in applying to register to vote, or
- choose your own political party or other political preference.

Send complaints to:

Colorado Secretary of State  
1700 Broadway  
Denver, CO 80290  
Phone: (303) 894-2200

## You may apply to register to vote or update your current registration today

- If you are not registered to vote where you live now, you may apply to register to vote here today.
- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

## Does filling out or not filling out the registration form affect services I am applying for?

No. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

## How private is this process?

The name and location of the agency or public office where you received the voter registration application will not appear on your records. If you decide not to use this application to register to vote, that is also confidential.

## Complete and sign below

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Please check only one of the following boxes. *If you do not check either box, you will be considered to have decided not to register to vote at this time.*

Yes, I want to apply to register to vote today. (Please fill out the Voter Registration Form)

You are eligible to vote if you:

- Will be 18 years of age or older at the time of the next election.
- Are a United States citizen.
- Are a Colorado resident and have lived in your current precinct for at least 30 days before the election.
- Are NOT serving a sentence (including parole) for a felony conviction.

No, I do not want to apply to register to vote today.

\_\_\_\_\_  
Your full name (please print)

\_\_\_\_\_  
Signature

## For office use only

Date: \_\_\_\_\_

The applicant completed a voter registration form

Yes  No

The applicant requested and was given a voter registration form for later delivery

Yes  No

Employee Initials: \_\_\_\_\_