For CCCAP Staff to Complete:	
Form Received Date:	**Case Number:**

Colorado Child Care Assistance Program (CCCAP)
Re-determination of Eligibility Form

Your current certification is ending and child care benefits will stop as of _____. Please complete and sign this re-determination form as soon as possible, or by _____. Without a signed re-determination form and required documents, we will be unable to determine your continued eligibility for 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 form must be submitted by the parent or primary guardian of the children needing child care.**
- **Completing this form does not guarantee continuing child care assistance past the dates identified above.**
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please provide all requested information listed on page 28 and as requested from your CCCAP caseworker.
- In order to avoid a delay in processing your redetermination and any additional follow up, please address each section and ensure that all information is completed and accurate.
- **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 1a: Contact Information for You, the Parent/Primary Guardian (REQUIRED)

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**) *If this has changed, please notify your CCCAP worker*:	Primary Phone: ( ) Type: ☐ Home ☐ Cell ☐ Voice Msg. ☐ Work	Secondary Phone: ( ) Type: ☐ Home ☐ Cell ☐ Voice Msg. ☐ Work

Preferred Contact Method: ☐ Phone ☐ Email ☐ Mail

Section 1b: For re-determination purposes, do any of the following describe where you live? (**REQUIRED**)

☐ 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): ____/_____/_____

Section 2a: Household Information (REQUIRED)
Please list every person that lives in your home starting with you.

Last Name, First Name, Middle Initial	Gender (M/F)	Date of Birth	How related to you? (self, additional guardian/ spouse, child)	If this person is a child, are you requesting care for this child?
			SELF	☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A
				☐ Yes ☐ No ☐ N/A

Section 2b: New Adults in your Home

REQUIRED: Are any of the adults listed in Section 2a new to your household since you completed the last CCCAP application or redetermination form?

☐ **Yes** ☐ **No**

If YES, you're required to complete the following table: Use additional paper if necessary.
If NO, skip to section 2c.

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)
			☐ Active Military (serving full time) ☐ Military Reserves ☐ National Guard			
			☐ Active Military (serving full time) ☐ Military Reserves ☐ 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

Section 2c: New Children in your Home

REQUIRED: Are any of the children listed in Section 2a new to your household since you completed the last CCCAP application or redetermination form?

☐ **Yes** ☐ **No**

If YES, you're required to complete the following table: Use additional paper if necessary.
If NO, skip to section 2d.

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Date of Birth	Gender	Does this child have a disability or special care need?	Citizenship Status:
				☐ Male ☐ Female	☐ Yes ☐ No	☐ Citizen ☐ Non-citizen ☐ Qualified Alien*

Hispanic or Latino?	Race(s): List all that apply (see codes below):	Immunization Status: traditional CDC vaccines, not COVID-19 vaccines (see codes below):
☐ Yes ☐ 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)	Date of Birth	Gender	Does this child have a disability or special care need?	Citizenship Status:
				☐ Male ☐ Female	☐ Yes ☐ No	☐ Citizen ☐ Non-citizen ☐ Qualified Alien*

Hispanic or Latino? ☐ Yes ☐ No	Race(s): List all that apply (see codes below):	Immunization Status: traditional CDC vaccines, not COVID-19 vaccines (see codes below):
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)	Date of Birth	Gender ☐ Male ☐ Female	Does this child have a disability or special care need? ☐ Yes ☐ No	Citizenship Status: ☐ Citizen ☐ Non-citizen ☐ Qualified Alien*

Hispanic or Latino? ☐ Yes ☐ No	Race(s): List all that apply (see codes below):	Immunization Status: traditional CDC vaccines, not COVID-19 vaccines (see codes below):
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 **NME**: Non-Medical Exemption **OT**: Other (explain)

Section 2d: Custody Arrangements

REQUIRED: Are there any children living in your household that are part of a Joint Custody agreement or another case?

☐ **Yes** ☐ **No**

* "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.

If YES, you're required to complete the following table. **If NO, skip to section 3.**		
Child's Name	**Joint Custody or another case**	**Date moved into custody arrangement**
	☐ Joint Custody ☐ Another custody case (please explain): _____	
	☐ Joint Custody ☐ Another custody case (please explain): _____	

Section 3: 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 already participate. ☐ I'd like to learn more. ☐ I am not interested.
Early Intervention Colorado: developmental supports available at no cost for children birth up to 3 years old	☐ I already participate. ☐ I'd like to learn more because I am concerned about my birth up to 3-year-old child's development. ☐ I am not interested.
Preschool Special Education: education supports available at no cost for 3- to 5-year-olds	☐ I already participate. ☐ I'd like to learn more because I am concerned about my 3- to 5-year-old child's development. ☐ I am not interested.

Colorado Works/Temporary Assistance for Needy Families (TANF) Cash Assistance: cash assistance for those who qualify	☐ I already participate. ☐ I'd like to learn more. ☐ I am not interested.
Food Assistance (SNAP): assistance buying food	☐ I already participate. ☐ I'd like to learn more. ☐ I am 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 already participate. ☐ I'd like to learn more. ☐ I am not interested.
Medicaid/CHP+ Health Insurance Assistance: health coverage for those who qualify.	☐ I already participate. ☐ I'd like to learn more. ☐ I am not interested.
Housing Choice Voucher or cash assistance: assistance paying my rent or utilities	☐ I already participate. ☐ I'd like to learn more. ☐ I am not interested.
Low-Income Energy Assistance (LEAP): assistance paying my heating bill	☐ I already participate. ☐ I'd like to learn more. ☐ I am not interested.
Refugee Medical Assistance: medical assistance for refugees	☐ I already participate. ☐ I'd like to learn more. ☐ I am not interested.

Section 4: Your Qualifying Activity

To be eligible for CCCAP, we need to determine your qualifying activity. Please include all accurate information in the following section. Verification of qualifying activity will be required.

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, please provide an employer letter.

REQUIRED: Section 4a.
Select ALL that apply and complete all requested information for your selected activity or activities.

☐ **Employed**

Start Date: _____

Employer Name: _____

Address: _____

Phone: _____

Number of hours per week: _____

Do you have another job?

☐ **No** ☐ **Yes (If YES, answer the questions below):**

Start Date: _____

Employer Name: _____

Address: _____

Phone: _____

Number of hours per week: _____

**If you have more than these two jobs, you may complete additional pages*

☐ **Self-employed**

☐ as an LLC
☐ as an S corp
☐ Other: _____

Number of hours per week: _____

☐ **Not working**

When did you stop working? (if applicable) _____

☐ **Looking for a job**

Start date (if applicable): _____

☐ **Disabled** Start date: _____

Is the disability:

☐ Permanent ☐ Temporary (end date: _____)

Are you able to take care of the child(ren)? ☐ Yes ☐ No

☐ **On maternity leave**

Start date: _____
Expected end date: _____

Physician Review Due Date **(if applicable):** _____	☐ **On strike** Start date: _____ Expected end date: _____ ☐ **On medical leave** Start date: _____ Expected end date: _____ ☐ **On a seasonal break** Start date: _____ Expected end date: _____

REQUIRED: Section 4b. Are you currently participating in training or education?

☐ **Yes** ☐ **No**

If YES, you're required to complete the table below. (VERIFICATION IS REQUIRED)
If NO, skip to Section 4c.

Name of Training/Education Institution:

Type of Training:	Effective Begin Date:	Anticipated Completion Date:	Number of Credits (if applicable):
☐ 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) Number of hours per week: _____			

Will this training/education result in a certificate/degree? ☐ Yes ☐ No

If YES, which type:

☐ High School Diploma/GED/High SchoolEquivalency ☐ Associate's Degree ☐ Bachelor's Degree

☐ Master's Degree ☐ Ph.D./Doctorate ☐ Certificate in _____

REQUIRED: Section 4c. Have you graduated within the last 12 months? ☐ **Yes** ☐ **No**

If YES, you're required to complete the table below.
If NO, skip to Section 5.

Degree obtained:

☐ High School Diploma/GED/High SchoolEquivalency ☐ Associate's Degree ☐ Bachelor's Degree

☐ Master's Degree ☐ Ph.D./Doctorate ☐ Certificate in _____

Section 5: Additional Guardian/Spouse Qualifying Activity

REQUIRED: Is there an additional guardian/spouse in your home? (If you are a teen parent, do not include your parents)

☐ Yes ☐ No

If YES, you're required to complete Sections 5a - 5c: (VERIFICATION IS REQUIRED)
If NO, skip to Section 6.

To be eligible for CCCAP, we need to determine your additional guardian/spouse's qualifying activity. Please include all accurate information in the following section. Verification of qualifying activity will be required.

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, please provide an employer letter.

5a. Select ALL that apply and complete all requested information for your selected activity or activities.

☐ **Employed**

Start Date: _____

Employer Name: _____

Address: _____

Phone: _____

Number of hours per week: _____

Do they have another job?

☐ **No**

☐ **Yes (If YES, answer the questions below):**

Start Date: _____

Employer Name: _____

Address: _____

Phone: _____

Number of hours per week: _____

**If additional guardian/spouse has more than these two jobs, additional pages may be completed.*

☐ **Self-employed**

☐ as an LLC

☐ as an S corp

☐ Other: _____

Number of hours per week: _____

☐ **Not working**

When did they stop working? (if applicable)_____

☐ **Looking for a job**

Start date (if applicable): _____

☐ **Disabled** Start date: _____

Is the disability:

☐ Permanent ☐ Temporary (end date: _____)

Are you able to take care of the child(ren)? ☐ Yes ☐ No

☐ **On maternity leave**

Start date: _____

Expected end date: _____

Physician Review Due Date **(if applicable)**: _____	☐ **On strike** Start date: _____ Expected end date: _____ ☐ **On medical leave** Start date: _____ Expected end date: _____ ☐ **On a seasonal break** Start date: _____ Expected end date: _____

Section 5b. Is the additional guardian/spouse currently participating in a training/education activity?

☐ **Yes** ☐ **No**

If YES, you're required to complete the table below. (VERIFICATION IS REQUIRED)
If NO, skip to Section 5c.

Name of Training/Education Institution:

Type of Training:	Effective Begin Date:	Anticipated Completion Date:	Number of Credits (if applicable):
☐ 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) Number of hours per week: _____			

Will this training/education result in a certificate/degree? ☐ Yes ☐ No

If YES, which type:

☐ High School Diploma/GED/High SchoolEquivalency ☐ Associate's Degree ☐ Bachelor's Degree

☐ Master's Degree ☐ Ph.D./Doctorate ☐ Certificate in _____

5c. Has the additional guardian/spouse graduated within the last 12 months? ☐ **Yes** ☐ **No**

If YES, you're required to complete the table below.
If NO, skip to Section 6.

Degree obtained:

☐ High School Diploma/GED/High SchoolEquivalency ☐ Associate's Degree ☐ Bachelor's Degree

☐ Master's Degree ☐ Ph.D./Doctorate ☐ Certificate in _____

Section 6: Work/Self-Employment Income

REQUIRED: Do you or 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.

Individual Name	How often Paid	Total earnings per pay period (including tips & commissions) ***before taxes***

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 all income coming into your household so your CCCAP specialist can determine if it is countable in deciding 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 each person 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):					

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

If your countable assets are worth more than $1,000,000 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 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**

If NO, skip to Section 10.

Non-liquid resources are non-cash assets that may include (but are not limited to): licensed/unlicensed automobile, RVs, real property, etc.

If YES, you're required to provide the amount of your non-liquid resources in dollars $_____

Section 10: 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 11: 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: ___/____/____

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.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. Revised 10/2020

YOU MUST READ AND SIGN THIS PAGE

You must submit the following documentation with this form:

IF YOU'VE HAD A CHANGE IN ADDRESS YOU NEED TO INCLUDE VERIFICATION OF RESIDENCY WHICH MAY INCLUDE ONE OF THE FOLLOWING:

- A lease agreement
- A utility bill
- A mortgage statement
- A paycheck stub with your address listed on it

IF YOU OR ANOTHER CARETAKER ON YOUR CASE ARE EMPLOYED OR SELF-EMPLOYED, YOU 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 your work schedule (your work schedule is only required if you are requesting care during the evening, overnight, or weekend hours). 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 (if requesting care during the evening, overnight, or weekend hours), number of hours/days you work per week, how often you will be paid, and the date of your first paycheck.

IF YOU OR ANOTHER CARETAKER ON YOUR CASE ARE IN AN EDUCATION/TRAINING ACTIVITY, YOU NEED TO INCLUDE:

A letter from your education/training institution which confirms your enrollment. This may include verification that:

1. Identifies the program you are enrolled in; and,
2. Identifies when you are expected to complete the program.
3. Start and end dates of quarter, semester, or session;
4. Days/times of class (if requesting care during the evening, overnight, or weekend hours); and,
5. 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 (if requesting care during the evening, overnight, or weekend hours)		Attach all education information		Attach verification of residence (if you've experienced a change in address)

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

Other Adult Caretaker Signature	Daytime Phone	Date

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.

RIGHT OF APPEAL AND FAIR HEARING

If you disagree with an action taken in regards to child care benefits, you have a right to:

- A local level dispute resolution conference which must be requested before the effective date of the proposed action;

- If you are dissatisfied with the outcome of the local dispute resolution conference, you may request a state level fair hearing before an administrative law judge if the written request for a hearing is mailed or delivered to the Office of Administrative Courts no later than 10 calendar days after the local level conference decision is mailed or delivered by the county;

- If you do not want to have a local/county conference to resolve the dispute, you may request a state level hearing before an administrative law judge, if the issue is appealable, and if your written request is mailed or delivered to the Office of Administrative Courts no later than 90 calendar days from the date of the notice
  of action;

- You may request judicial review of the final agency decision following the state level fair hearing in district court, after exhausting all administrative appeal rights; and

- If you have been receiving child care assistance, you may request continued assistance until the dispute is resolved or until the final agency decision is issued, if the request for a local conference and/or state level hearing is made before the effective date of the proposed action being appealed. You should be aware that the state and county are required to attempt to collect or get repayment of all benefits provided to you for which you were not eligible.

If you request a local conference, the county will schedule that conference. At your conference, you will be given an opportunity to present your case. The person(s) reviewing your case will not be the same person responsible for the action in dispute. Before you decide to request a local dispute resolution conference, we encourage you to talk with your county child care worker, and then the worker's supervisor. Often your questions and concerns can be settled by talking to county staff that is responsible for making the change in your child care subsidies.

If you want to request a state level fair hearing, your request must be sent or delivered to:

Office of Administrative Courts
1525 Sherman St.
4th Floor
Denver, Colorado 80203

- In the letter you need to say that you want to appeal the county's action and why you want to appeal that action. If you need help doing this you can ask anyone you like to help you, talk to a legal aid office or attorney, or ask your child care worker to help you.

- When your letter is received, you will get a letter from the Office of Administrative Courts explaining what will be done and the date for the appeal hearing. It will also explain who can come with you, who can present testimony and other information about the hearing.

- Throughout the appeal process, you have the right to be represented or assisted by legal counsel, a relative, a friend or a spokesperson of your choosing.

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 Visitation/Custody

Please complete this required form for all children requesting CCAP care that have visitation with a parent/guardian who lives outside your home.

Is there a visitation agreement for this child? Yes ☐ No ☐
If not, skip down to the bottom and sign.

If you have a visitation agreement, please complete the Visitation Schedule Calendar below for each child that needs CCAP and has visitation with a parent outside your home. Complete the schedule with days, times, and dates your child is with their other parent.

Child's name	MON	TUES	WED	THUR	FRI	SAT	SUN

Please include any other information about your child's visitation schedule that is more specific with dates (e.g. variable schedule, rotating schedule, every other week, etc.): _____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature

3460 N. Broadway Boulder, CO. 80304 or
515 Coffman St Suite 100 Longmont, CO 80501
Phone: 303 441-1000, Fax: 303 441-1523
Rev. 12.2021

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 ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
School Aged:	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Type of care	FT ☐ PT ☐	FT ☐ PT ☐	FT ☐ PT ☐
School Aged only:	BEFORE ONLY ☐ AFTER ONLY ☐ B/A ☐ Full time NON-SCHOOL days ☐ FT SUMMER ☐	BEFORE ONLY ☐ AFTER ONLY ☐ B/A ☐ Full time NON-SCHOOL days ☐ FT SUMMER ☐	BEFORE ONLY ☐ AFTER ONLY ☐ B/A ☐ Full time NON-SCHOOL days ☐ FT SUMMER ☐

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

(Rev. 06.2022)