Boulder County Child Care Assistance Program (CCAP)

How to submit in-person:

3460 N. Broadway, Boulder, CO. 80304 OR 515 Coffman Street, Longmont, CO 80501

E-mail: ssboulderimaging@bouldercounty.gov *or* fax: 303-441-1523

☐ New Provider
☐ Change of Provider
☐ Schedule Change – including summer, school breaks and school off-days.

CCAP Parents or Adults Caretaker Please Note:

- You must allow 15 days' notice to your CCAP worker to change providers. Including changes for non-school days/breaks. Contact your CCAP caseworker in an emergency situation.
- You must contact your child care provider directly regarding the amount of notice: you may have signed a contract that specifies a required Notice Period (Example: "2 weeks' notice").
- You must have paid your parent fee in full or have made acceptable payment arrangements before you can change providers. This will be verified with your current provider.

SS# ______________________ CCAP Client's Name: ______________________

Current Provider: ______________________

End Date w/Current Provider: ______________________

New Provider Name: ______________________ Director/Contact: ______________________
(if applicable)

New Provider License Number:______________________ Start Date w/New Provider: ______________

Phone:______________________ Fax: ______________________

For School Age Children:

School Start/End Date: ______________________
(circle one)

Care Needed for (√ all that apply): ☐ Before School ☐ After School ☐ Full-Time Summer Care

Notes: (list children's names, schedule, and/or any other specifics on page provided)

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CCAP Client Signature: ______________________ Date: ______________________

CCAP Provider Change form.pdf

Boulder County Change of CCAP Care Request form

Child's Name:____

CCAP Provider Name: _____________________________________

Provider Address:____ Provider ID: ________ (Mandatory)

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

County Use only: child's age at time of application: ________Care level at time of application:_______

Additional Child's Name:___________________________________

CCAP Provider Name: _____________________________________

Provider Address:____ Provider ID: ________ (Mandatory)

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

County Use only: child's age at time of application: ________Care level at time of application:_______

Additional Child's Name:___________________________________

CCAP Provider Name: _____________________________________

Provider Address:____ Provider ID: ________ (Mandatory)

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

County Use only: child's age at time of application: ________Care level at time of application:_______

Copy this page as needed for additional child schedules.

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