



Boulder County Child Care Assistance Program (CCAP) Verification of Temporary Leave

The following information is necessary for CCAP to determine eligibility for your employee.
Please complete this form and email to: imaging@bouldercounty.gov.

Employee Name: _____ Case/SS#: _____

Name of Employer: _____

Date Leave Starts: _____ Anticipated Return Date: _____

The temporary leave is: Paid Unpaid

If paid, how much will the employee receive per month: \$ _____

The temporary leave is: Maternity/Paternity Medical

Rate of pay upon return to work: \$ _____ per hour. If salary, \$ _____ per month.

Please report the employee's anticipated return-to-work schedule (i.e. 9a-5p written within the grid below for each day the employee is expected to work):

| SUN | MON | TUE | WED | THUR | FRI | SAT | TOTAL HRS PER WEEK |
|-----|-----|-----|-----|------|-----|-----|-----------------------|
| | | | | | | | |

OR

If employee works a **FLEXIBLE SCHEDULE**, please tell us when they are available to work:

Earliest time in _____ **am/pm AND Latest time out** _____ **am/pm**

Average Hours Per Week: _____

Days of week expected to be available: Check all that apply: M T W TH F ST SN

I confirm that the above information is complete and accurate:

Printed Name of Employer/Supervisor

Title

Phone Number

Signature of Employer/Supervisor

Date