DEPARTMENT OF HUMAN SERVICES

Child Care Assistance Program
1501 Blue Spruce Drive
Fort Collins, CO 80524
(970) 498-6300
Fax: (970) 498-7987
CCAP@co.larimer.co.us

- A face-to-face interview is not required for the Child Care Assistance Program. You will be contacted via phone or mail.
- Please be sure to answer all questions on the application and provide all verification. Your application will be denied for leaving sections blank (fill in with not applicable or N/A).
- Original citizenship and identity verification must be viewed by someone in our office.
- Cooperation with Child Support Enforcement is mandatory. If you do not already have an open Child Support case you will be required to enroll in and cooperate with Child Support. If you believe seeking support from the absent parent would put you or your child in harm, you have the right to request a good cause exemption.

General Program Information/Questions (970) 498-6300, option 4

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PLEASE TURN IN A <u>COMPLETE</u> APPLICATION

Required CCAP Verifications:

- ☐ Attested (original must be viewed by staff) birth certificates for every child that needs daycare, even if only for school out days
- ☐ Attested (original must be viewed by staff) or notarized driver's license or state-issued ID for each parent in the household
- ☐ Verification of your address (ie: a lease, bill, vehicle or voter registration, tax form, etc.)
- ☐ Daycare information (name, address, phone number) and schedule for each child

  *** If you do not have a provider and need assistance, please call the Mile High United Way's Child Care Options at 1-877-338-CARE (2273).*
- ☐ Verifications for each parents' activities. If you are in more than one activity (ie, working and going to school), you must provide verifications for BOTH activities. See list below.

  ***If you are employed, we will need*:**
  - ☐ A copy of your work schedule (this can be completed on the enclosed employer letter)
  - ☐ Your last month of pay stubs. If the job is new and you do not have enough pay stubs, please have your employer complete the income information on the employer letter

  ***If you are self-employed, we will need*:**
  - ☐ Profit and loss statements & receipts for the last month. If you do not have profit and loss statements, you can pick up a self-employment packet at Human Services to complete instead. All calculations MUST be calculated before your interview, and you MUST attach copies of appropriate receipts for all income and deductions.
  - ☐ Federal Employer Identification Number, LLC or S-Corp verification, a sales tax license, or any other tax paperwork showing you are self-employed. If you do not have this, you can apply for an EIN at www.irs.gov or at a local IRS office.

  If you are job searching, we will need:
  - ☐ A copy of your job search schedule

  ***If you are attending school, we will need*:**
  - ☐ A copy of your class schedule. If your classes are online, we need verification of that.

If you are receiving any other income, we will need verification. For example, if you are receiving child support, please bring FSR receipts, a court order, or a copy of a check. If you are receiving Unemployment Benefits, please bring in a letter showing your weekly benefit amount.

If you share custody of your child with the other parent, please bring a copy of a court order or a letter signed by both parents indicating the parenting time schedule.

Please note that this list may not include all verifications needed. Every case is different, and extra documentation may be requested by your technician under certain circumstances. We cannot set up or authorize any child care until all of your verifications are received. Having all of your verifications with your application will ensure faster processing of your case.

<u>Cooperation with Child Support Enforcement is mandatory.</u>

Fort Collins Office Hours:
Monday 8:00 – 3:00 p.m.
Tuesday 8:00 – 3:00 p.m.
Thursday 8:00 – 3:00 p.m.
Friday 8:00 – 3:00 p.m.

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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.

Pay stubs for the past month and an employer letter on company letterhead. This letter must include:

- Name and address of the company;
- Date you began working
- Number of hours you work each week;
- Schedule
- Amount you are paid per hour;
- 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

Verification of any unearned income, which would include:

- Child support
- Unemployment
- Regular help from friends or relatives
- Social Security
- Workman's Compensation
- Any other monies received by your household that is not from employment

Verification of the Citizenship status of the children you are requesting care for (original must be viewed by staff).

- Birth Certificate
- Possession of a U.S. passport
- Certificate of Naturalization
- Identification cards for U.S. citizens
- A certificate of U.S. citizenship
- Certificate of birth abroad of a citizen of the United States

Verification of Identity for Parents in the Household (original must be viewed by staff):

- Official Picture Identification (original)

Other

- 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).

If you are attending school or GED program, you are required to submit the following information:

- School advisor's statement of completion date or graduation date
- Copy of class schedule issued by your school

165% of the Federal Poverty **Effective 10/1/2015**	
Family Size	Monthly Income
2	$2,190
3	$2,762
4	$3,334
5	$3,906
6	$4,478
7	$5,050
8	$5,622
9	$6,194

*** If you do not have a provider and need assistance please call the Mile High United Way's Child Care Options, at 1-877-338-CARE (2273).*

Can we call you Monday through Friday between 8:00 a.m. and 4:30 p.m.?

☐ **Yes** ☐ **No**

If yes, phone number: ________________ **best time to call:** ________

Fort Collins Office Hours

1501 Blue Spruce Drive

Monday 8:00-3:00 p.m.

Tuesday 8:00-3:00 p.m.

Thursday 8:00-3:00 p.m.

Friday 8:00-3:00 p.m.

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Application Received Date:	Pre-Eligibility: Yes ☐ No ☐ Determined by: Provider ☐ County ☐	Case Number:

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*?	☐ Yes ☐ No ☐ Yes ☐ 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? **Please complete if applicable.**	☐ Living in hotel or motel	☐Living in campground	☐ Living in shelter	☐ Living in substandard housing such as car, park, etc.
	☐ Living situation (please explain)		Date living situation began: ____/_____/________ Anticipated end date: ____/_____/________	

Residence Address*:			Mailing Address*: ☐ Same as residence?		
City*:	State*:	Zip*:	City*:	State*:	Zip*:
County*:			Primary language spoken in the home*:		

Contact Information: *Complete at least one*	Primary Phone*: ( ) Type:☐ Home ☐Cell ☐ Voice Msg.☐ Work	Secondary Phone*: ( ) Type:☐ Home ☐Cell ☐ Voice Msg.☐ Work	Email Address:

Do you or anyone else in your household receive benefits from or participate in any of the following programs?		**If no, would you like to receive more information?**
Colorado Works/TANF cash assistance	☐ Yes ☐ No	☐ Yes ☐ No
Head Start/Early Head Start	☐ Yes ☐ No	☐ Yes ☐ No
Low-Income Energy Assistance (LEAP)	☐ Yes ☐ No	☐ Yes ☐ No
Food Assistance (SNAP)	☐ Yes ☐ No	☐ Yes ☐ No
Women, Infants and Children (WIC) Program	☐ Yes ☐ No	☐ Yes ☐ No
Child and Adult Care Food Program	☐ Yes ☐ No	☐ Yes ☐ No
Medicaid/CHP+ Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Housing voucher or cash assistance	☐ Yes ☐ No	☐ Yes ☐ No
Refugee Medical Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Individuals with Disabilities Education (IDEA) Services Part B (3-5yrs)	☐ Yes ☐ No	☐ Yes ☐ No
Individuals with Disabilities Education (IDEA) Services Part C (0-3yrs)	☐ Yes ☐ No	☐ Yes ☐ No
Old Age Pension	☐ Yes ☐ No	☐ Yes ☐ No
Other (please explain):_________________	☐ Yes ☐ No	☐ Yes ☐ No

All Items Marked with (*) on this application MUST be completed

Section 2: Primary Caretaker Information

*Last Name:	*First Name:	Middle Initial:

Social Security Number: _____-____-___________ (Optional)	Date of Birth (MM/DD/YYYY)*: ____/____/_______	Gender*: ☐ Male ☐Female

Race (optional, mark all that apply):	☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic
	☐ Asian	☐ Black	☐ White	☐ Other	

Highest Grade Completed*:	☐ Less Than High School/High School Equivalency	☐ High School/High School Equivalency	☐ Associate Degree	☐ Bachelor Degree
	☐ Graduate Degree	☐ PhD/Doctorate	☐ Unknown	☐ Other __________

Marital Status*:	☐ Married, Living w/Spouse	☐ Married, Not Living w/Spouse (voluntarily)	☐ Married, Not Living w/Spouse (involuntarily)	
	☐ Significant Other	☐ Single – Never Married	☐ Widowed/Widower	☐ Divorced

ACTIVITY*: Check all that apply to this individual			
☐ Employed	☐ Self-Employed	☐ Job Search	☐ Post-Secondary School
☐ Training/Education	☐ English as a second language	☐ GED/High School Equivalency	☐ Middle / Jr. High
☐ Disabled	☐ National Guard	☐ Military Reserves	☐ 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*: ☐ Male ☐Female	Relationship to the Primary Adult Caretaker*:

Race (optional, mark all that apply):	☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic
	☐ Asian	☐ Black	☐ White	☐ Other	

Highest Grade Completed*:	☐ Less Than High School/High School Equivalency	☐ High School/High School Equivalency	☐ Associate Degree	☐ Bachelor Degree
	☐ Graduate Degree	☐ PhD/Doctorate	☐ Unknown	☐ Other __________

Marital Status*:	☐ Married, Living w/Spouse	☐ Married, Not Living w/Spouse (voluntarily)	☐ Married, Not Living w/Spouse (involuntarily)	
	☐ Significant Other	☐ Single – Never Married	☐ Widowed/Widower	☐ Divorced

ACTIVITY*: Check all that apply to this individual			
☐ Employed	☐ Self-Employed	☐ Job Search	☐ Post-Secondary School
☐ Training/Education	☐ English as a second language	☐ GED/High School Equivalency	☐ Middle / Jr. High
☐ Disabled	☐ National Guard	☐ Military Reserves	☐ Active Military (serving full time)

All Items Marked with (*) on this application MUST be completed

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*:	Relationship to the Primary Adult Caretaker*:
______-_____-_____________	_____/_____/________	☐ Male ☐ Female	

Citizenship Status*:	Race (optional, mark all that apply):					Ethnicity (optional):
☐Citizen ☐Non-citizen ☐ Qualified Alien		☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		☐ Hispanic ☐ Non-Hispanic
		☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ No
If your child is not 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?	☐Yes ☐ 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*:	Relationship to the Primary Adult Caretaker*:
______-_____-_____________	_____/_____/________	☐ Male ☐ Female	

Citizenship Status*:	Race (optional, mark all that apply):					Ethnicity (optional):
☐Citizen ☐Non-citizen ☐ Qualified Alien		☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		☐ Hispanic ☐ Non-Hispanic
		☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ No
If your child is not 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?	☐Yes ☐ No

All Items Marked with (*) on this application MUST be completed

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*: ☐ Male ☐ Female	Relationship to the Primary Adult Caretaker*:

Citizenship Status*: ☐Citizen ☐Non-citizen ☐ Qualified Alien	Race (optional, mark all that apply):	☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic
		☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ No
If your child is not 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?	☐Yes ☐ 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*: _____/_____/________	Gender*: ☐ Male ☐Female	Relationship to the Primary Adult Caretaker*:

Citizenship Status*: ☐Citizen ☐Non-citizen ☐ Qualified Alien	Race (optional, mark all that apply):	☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic
		☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ No
If your child is not 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?	☐Yes ☐ No

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN

Page _________of ___________

All Items Marked with (*) on this application MUST be completed

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)
			☐ Yes ☐ No	☐Yes ☐ No			$
			☐ Yes ☐ No	☐Yes ☐ 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)
			☐ Yes ☐ No	☐ Yes ☐ No			$
			☐ Yes ☐ No	☐ Yes ☐ 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
	☐ Yes ☐ No	☐ Yes ☐ No			
	☐ Yes ☐ No	☐ Yes ☐ No			

All Items Marked with (*) on this application MUST be completed

Section 9: Other Income* **Complete information in Section 9 for each person in your household.**			
Individual Name:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Other Income Types: 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)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	☐ Yes ☐ No If yes, list amount: $______________	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	☐ Yes ☐ No If yes, list amount: $______________
Individual Name:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Other Income Types: 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)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments)	☐ Yes ☐ No If yes, list amount: $______________	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	☐ Yes ☐ 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*: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐Post-Secondary Education ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐Certificate Program	Anticipated Completion Date*:
Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution*:	Type of Training*: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐Post-Secondary Education ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐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*: ☐ Permanent ☐Temporary	Is this Individual able to take care of the child(ren)?* ☐ Yes ☐ No	Physician Review Due Date, if applicable:	
Name*:		Disability Begin Date*:	Disability End Date:
Disability Type*: ☐ Permanent ☐Temporary	Is this Individual able to take care of the child(ren)?* ☐ Yes ☐ 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
MY SCHEDULE							
Work/Job Search							
Training/School							
2ND ADULT CARETAKER	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	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*
	☐Yes ☐No									
	☐Yes ☐No									
	☐Yes ☐No									
	☐Yes ☐No									

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:________________

YOU MUST ALSO READ AND SIGN THIS PAGE

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.

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 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.

   Circle household size and State Median Income (SMI) amount

Household Size	2	3	4	5	6	7	8	9	10+
85% SMI	$4,139	$5,112	$6,086	$7,059	$8,033	$8,215	$8,398	$8,581	+$4,160 per add. member

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. (By providing education/training or work schedules at re-determination and whenever my activity changes.)
4. I agree that I will provide job search logs as required by the County.
5. I agree that if I am in education/training (county option) that I will maintain satisfactory progress to remain eligible for child care assistance for this activity. Satisfactory progress is a GPA of at least a 2.0 or its equivalent or have academic standing consistent with the institution's graduation requirements.
6. I agree to notify my child care worker in writing at least ten (10) days BEFORE changing child care providers otherwise the county may not pay for my child care.
7. I agree to be responsible for resolving any problems I might have with my child care provider.
8. 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.
9. 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. I also understand that I must provide documentation from the IRS or other government agency to verify my self-employment status.
10. I understand that if child care is provided for my employment activity then the taxable gross wages divided by the number of hours I use child care for my employment must equal at least the current federal minimum wage in order to continue receiving child care.
11. I agree that if my county requires child support enforcement I will cooperate with the child support enforcement office for any child that has an absent parent regardless of whether they receive child care assistance.
12. I agree that I will not leave my CCAP card in the possession of my child care provider at any time or I may be disqualified from the Colorado Child Care Assistance Program.
13. I agree to use my CCAP card to check my child(ren) in and out of care daily or my child care assistance case may close and I shall be responsible for payment of the child care costs.
14. 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.
15. PARENTAL FEE:
    a. I agree to pay the parental fee listed on my child care authorization notice and that it is due to the provider on the first day of each month.
    b. I understand that my parental 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 and will not be able to receive assistance with another child care provider and/or through any other county.

Applicant 1 Signature	Date	Applicant 2 Signature	Date

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
   4th 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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DEPARTMENT OF HUMAN SERVICES

Child Care Assistance Program
1501 Blue Spruce Drive
Fort Collins, CO 80524
(970) 498-6300
Fax: (970) 498-7987

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: .

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

☐ **Change in Schedule** **Effective Date:** ____________

☐ **Employee's Daily Work Schedule & Availability:**
MUST BE FILLED OUT! Do not use "varies".

	BEGINNING TIME	ENDING TIME		BEGINNING TIME	ENDING TIME
MONDAY:			THURSDAY:		
TUESDAY:			FRIDAY:		
WEDNESDAY			SATURDAY:		
			SUNDAY:		

☐ **Approximately how many days per week is the employee expected to work?**

☐ 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 # ____________

LCHS 4216 (04/13)

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):

   ____

   ____

LARIMER COUNTY
COMMITTED TO EXCELLENCE

DEPARTMENT OF HUMAN SERVICES

Child Care Assistance Program
(970) 498-6300

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**

DEPARTMENT OF HUMAN SERVICES

Child Care Assistance Program

(970) 498-6300 Fax (970) 498-7987

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Voter Registration Choice Form

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: __________

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 Today's date (MM/DD/YY)