



CHANGES IN EMPLOYMENT

The following information is necessary to determine eligibility for Child Care Assistance.

CCAP Caseworker Name or Ext.: _____ Date: _____

TO BE COMPLETED BY EMPLOYER

Employee Name: _____ Social Security #: _____

Name of Business: _____

City/State/Zip

Address: _____

Type of Change: Schedule Income Other (Please specify): _____

First day of New Schedule: _____ First Check Date w/Changes: _____

UPDATED WEEKLY WORK SCHEDULE:

SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS PER WEEK

Please fill in above weekly schedule-If flex schedules please mark any regular days off (OFF)
Fill in other days as best you can, include earliest time in/latest time off.

**If FLEX schedule: Average hours per week _____ (min # hrs) _____ (max # hrs)
Earliest time in _____ Latest time out _____**

If FLEX schedule: Average hours per week _____ (min # hrs) _____ (max # hrs)
Earliest time in _____ Latest time out _____

Rate of Pay: _____ Monthly Gross Wages: _____ Taxes Withheld Yes No

Additional income (overtime/commission/bonuses/tips*) Yes (if yes, complete the following) No

How often paid? Weekly Biweekly Semimonthly Monthly/Other _____

*If tips, what percentage is reported: _____

The above person has indicated that s/he is employed with your business. Please complete the following information and return to employee or directly to AFS at the address or number at the bottom of page.

I confirm that the above information is complete and accurate:

Printed Name

Title

Phone Number

Date

Signature

Date

Boulder County Child Care Assistance Program (CCAP)

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

**Phone: (303) 678-6014
Fax: (303) 441-1523**