



## **Boulder County Child Care Assistance Program (CCAP) Check-List**

In order for your household to be determined for CCAP benefits you will need to turn in the following to the County Office.

- Your completed and signed CCAP application- this can be done online through PEAK.  
Complete this application to the best of your ability and please do not leave any blank spaces.
- Your signed CRA- Client Responsibilities Agreement – this is also available through PEAK

### **~AND~**

- Verification of County Residency: this can be a current utility bill, current lease, current landlord letter, or current auto registration.
- Verification of Identity: this is an unexpired picture ID for adult applicant.
- Verification of Citizenship: this is a copy of a US birth certificate or US passport for all children requesting care.
- Verification of all EARNED income for all adults on CCAP case:
  - VOE- Verification of Employment letter for any **NEW** employment (within last 60 days); **OR**
  - Last 30 days of current paystubs for ESTABLISHED employment **older** than 60 days; **OR**
  - Self- Employed persons:
    - **Please provide your last 30 days of current income and hours worked.**
- Verification of any UNEARNED income: Including but not limited to Child Support, Unemployment, or Social Security.
- If in school/training activity: Verification of Program of Study and Unofficial Transcript
- Verification of eligible activity schedule: only if care is needed outside of traditional care hours of 6am to 630pm Monday-Friday.
- Child Visitation Schedule: Complete the attached visitation form if the child (ren) you are requesting care for have visitation with a non-custodial parent.
- Child Care Provider/ Location/ License number (\* see below for Child Care Referral Information)

*Please Note: This is not an inclusive list and there may be other items needed based on your individual circumstances, the technician working your case will let you know if other verification is needed.*

Need help finding a Child Care provider please contact the Child Care Resource and Referrals line at:  
1-877-338-2273



**WHO IS ELIGIBLE?** Boulder County Children ages 0 to 12 years who live with:

- An adult or teen caretaker/parent that is in an eligible activity
  - Employed/ self-employed
  - Job Searching (thirteen (13) weeks available per 12 month cycle)
  - Post-Secondary Educational Activities (104 weeks and up to first Bachelor’s degree)
  - Educational Activities (teen parents in JR or SR High School, GED classes, ESL, and Adult Basic Ed/ Vocational Training)
- Families receiving Colorado Works/ TANF and referred by their Case Manager

**INCOME ELIGIBILITY:** Must be within the current posted income guidelines (subject to change)

Family size	2	3	4	5	6	7	8
Max. monthly gross income	3007	3787	4567	5347	6127	6907	7687

**PROGRAM REQUIREMENTS:**

- Must be County Resident ,
- Must cooperate with Child Support Services for all children requesting care,
- Must pay a portion of care or parent fee based on household income,
- Must choose a CCAP eligible child care provider,
- Must be approved **before** using care,
- And for continued assistance you must complete the CCAP redetermination process every twelve (12) months.

CCAP technician will determine eligibility based on information provided by you on your application and any verification submitted or obtained to support application statements. Once you are determined eligible you will be notified as well as your child care provider as to care authorized. It is required that you use the ATTENDANCE TRACKING method utilized for CCAP by your provider. Any missed tracking will be the financial responsibility of you, the CCAP client.

For further assistance with this process contact the  
 Boulder County CCAP Team at:  
 303.678.6014 or  
 Email [ccap@bouldercounty.org](mailto:ccap@bouldercounty.org)  
[www.bouldercountyccap.org](http://www.bouldercountyccap.org)

Application Received Date:	Pre-Eligibility: Yes <input type="checkbox"/> No <input type="checkbox"/> Determined by: Provider <input type="checkbox"/> County <input type="checkbox"/>	Case Number:
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## 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*?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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? <b>Please complete if applicable.</b>	<input type="checkbox"/> Living in hotel or motel	<input type="checkbox"/> Living in campground	<input type="checkbox"/> Living in shelter	<input type="checkbox"/> Living in substandard housing such as car, park, etc.	
	<input type="checkbox"/> Living situation (please explain)		Date living situation began: ____/____/____ Anticipated end date: ____/____/____		
Residence Address*:			Mailing Address*: <input type="checkbox"/> Same as residence?		
City*:	State*:	Zip*:	City*:	State*:	Zip*:
County*:			Primary language spoken in the home*:		
Contact Information: <i>*Complete at least one</i>	Primary Phone*: ( ) ( ) Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	Secondary Phone*: ( ) ( ) Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	Email Address:		
<b>Do you or anyone else in your household receive benefits from or participate in any of the following programs?</b>				<b>If no, would you like to receive more information?</b>	
Colorado Works/TANF cash assistance				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Start/Early Head Start				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low-Income Energy Assistance (LEAP)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Assistance (SNAP)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Women, Infants and Children (WIC) Program				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child and Adult Care Food Program				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid/CHP+ Assistance				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Housing voucher or cash assistance				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Refugee Medical Assistance				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individuals with Disabilities Education (IDEA) Services Part B (3-5yrs)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individuals with Disabilities Education (IDEA) Services Part C (0-3yrs)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Old Age Pension				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (please explain): _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2: Primary Caretaker Information				
*Last Name:		*First Name:		Middle Initial:
Social Security Number: _____ - _____ - _____ (Optional)		Date of Birth (MM/DD/YYYY)*: _____ / _____ / _____		Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White	
Highest Grade Completed*:	<input type="checkbox"/> Less Than High School/High School Equivalency	<input type="checkbox"/> High School/High School Equivalency	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor Degree
	<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> PhD/Doctorate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
Marital Status*:	<input type="checkbox"/> Married, Living w/Spouse	<input type="checkbox"/> Married, Not Living w/Spouse (voluntarily)	<input type="checkbox"/> Married, Not Living w/Spouse (involuntarily)	
	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single – Never Married	<input type="checkbox"/> Widowed/Widower	<input type="checkbox"/> Divorced
<b>ACTIVITY*: Check all that apply to this individual</b>				
<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Job Search	<input type="checkbox"/> Post-Secondary School	
<input type="checkbox"/> Training/Education	<input type="checkbox"/> English as a second language	<input type="checkbox"/> GED/High School Equivalency	<input type="checkbox"/> Middle / Jr. High	
<input type="checkbox"/> Disabled	<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	<input type="checkbox"/> Active Military (serving full time)	

Section 3: Additional Adult Caretaker/Spouse				
<b>**An additional adult caretaker in the household is one who provides financial assistance and helps care for your child</b>				
*Last Name:		*First Name:		Middle Initial:
Social Security Number: _____ - _____ - _____ (Optional)		Date of Birth (MM/DD/YYYY)*: _____ / _____ / _____		Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to the Primary Adult Caretaker*:				
Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White	
Highest Grade Completed*:	<input type="checkbox"/> Less Than High School/High School Equivalency	<input type="checkbox"/> High School/High School Equivalency	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor Degree
	<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> PhD/Doctorate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
Marital Status*:	<input type="checkbox"/> Married, Living w/Spouse	<input type="checkbox"/> Married, Not Living w/Spouse (voluntarily)	<input type="checkbox"/> Married, Not Living w/Spouse (involuntarily)	
	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single – Never Married	<input type="checkbox"/> Widowed/Widower	<input type="checkbox"/> Divorced
<b>ACTIVITY*: Check all that apply to this individual</b>				
<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Job Search	<input type="checkbox"/> Post-Secondary School	
<input type="checkbox"/> Training/Education	<input type="checkbox"/> English as a second language	<input type="checkbox"/> GED/High School Equivalency	<input type="checkbox"/> Middle / Jr. High	
<input type="checkbox"/> Disabled	<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	<input type="checkbox"/> Active Military (serving full time)	

**Section 4: Child Information \*\*Complete this section for each child in your home**

Last Name*:	First Name*:	Middle Initial:
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Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY)*: ____/____/____	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker*:
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Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you requesting care for this child?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have a disability or have additional care needs?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start: ____/____/____ End: ____/____/____		

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your child is <u>not</u> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 4 Cont'd \*\*Complete this section for each child in your home**

Last Name*:	First Name*:	Middle Initial:
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Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY)*: ____/____/____	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker*:
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Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you requesting care for this child?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have a disability or have additional care needs?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start: ____/____/____ End: ____/____/____		

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your child is <u>not</u> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Section 4 Cont'd \*\*Complete this section for each child in your home**

Last Name*:		First Name*:		Middle Initial:
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Social Security Number (Optional): ____ - ____ - _____	Date of Birth (MM/DD/YYYY)*: ____ / ____ / _____	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker*:
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Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have a disability or have additional care needs?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start: ____ / ____ / _____ End: ____ / ____ / _____		

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If your child is <u>not</u> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**Section 4 Cont'd \*\*Complete this section for each child in your home**

Last Name*:		First Name*:		Middle Initial:
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Social Security Number (Optional): ____ - ____ - _____	Date of Birth*: ____ / ____ / _____	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker*:
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Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have a disability or have additional care needs?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start: ____ / ____ / _____ End: ____ / ____ / _____		

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If your child is <u>not</u> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN

Page \_\_\_\_\_ of \_\_\_\_\_

**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)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			



<b>Section 9: Other Income*</b> Complete information in Section 9 for <u>each person</u> in your household.			
<b>Individual Name:</b>	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
<b>Other Income Types:</b> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Assets:</b> Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____
<b>Individual Name:</b>	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
<b>Other Income Types:</b> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Assets:</b> Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount: \$ _____

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS

Page \_\_\_\_\_ of \_\_\_\_\_

<b>Section 10: Adult Caretaker Training/Education/Teen Education Detail</b>			
Are you or another household member participating in a training/education activity?* <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, complete the following: (VERIFICATION IS REQUIRED)			
Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution*:	Type of Training*: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> English As A Second Language (ESL) <input type="checkbox"/> Post-Secondary Education <input type="checkbox"/> GED/High School Equivalency <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date*:
Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution*:	Type of Training*: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> English As A Second Language (ESL) <input type="checkbox"/> Post-Secondary Education <input type="checkbox"/> GED/High School Equivalency <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date*:

<b>Section 11: Adult Caretaker Disability Detail</b>			
Are you or another Adult Caretaker disabled?* <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, complete the following: (VERIFICATION IS REQUIRED)			
Name*:		Disability Begin Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Is this Individual able to take care of the child(ren)?* <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Review Due Date, if applicable:	
Name*:		Disability Begin Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Is this Individual able to take care of the child(ren)?* <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Review Due Date, if applicable:	

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

<b>Section 12: Adult Caretaker(s) Employment/Training/School/Job Search Schedule*</b>							
<b>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.)</b>							
<b>Example</b>	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
<b>MY SCHEDULE</b>							
Work/Job Search							
Training/School							
<b>2ND ADULT CARETAKER</b>	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							

<b>Section 13: Children's Schedule for children needing care* (Do not complete for children who do not need care.)</b>										
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
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									

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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

- 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
85% SMI	\$4,235.20	\$5,231.72	\$6,228.23	\$7,224.75	\$8,221.27	\$8,408.12	\$8,594.96	\$8,781.81

- I agree that I must complete the redetermination process when it is due, including all required verification.
- I agree that I must verify my eligible activity when there is a change in my eligible activity and at re-determination. (A schedule will be required if you are self-employed or when non-traditional care such as overnight, weekend, or evening care, is needed)
- I agree to notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.
- I agree to be responsible for resolving any problems I might have with my child care provider.
- 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.
- 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 understand that if child care is provided for my employment or self-employment activity then the taxable gross wages divided by the number of hours I work must equal at least the current federal minimum wage in order to continue receiving child care.
- I agree that if my county requires child support enforcement I will cooperate with the child support enforcement office for any child that is receiving care and has an absent parent.
- 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.
- 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.
- I understand that if my CCAP card has been lost, stolen, or damaged, I must notify my child care worker within two (2) business days.
- I understand that if new CCAP cards are issued to me, I must report non-receipt of the cards within five (5) business days.
- 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.
- PARENT FEE:**
  - I agree to pay the parent fee listed on my child care authorization notice and that it is due to the provider in the month that care is received.
  - I understand that my parent 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.
  - 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  
4<sup>th</sup> 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

# Boulder County CCAP EMPLOYMENT/INCOME VERIFICATION

## Form must be completed by employer

CCAP Client Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name of Business: \_\_\_\_\_

Business Address: \_\_\_\_\_

City/State/Zip

First Day of Employment: \_\_\_\_\_ First Check Date: \_\_\_\_\_

Job Title: \_\_\_\_\_

Rate of Pay: \_\_\_\_\_ Monthly Gross Wages: \_\_\_\_\_ Taxes Withheld  Yes  No

How often paid?  Weekly  Biweekly  Semimonthly  Monthly/Other \_\_\_\_\_

\*If tips, what percentage is reported: \_\_\_\_\_

Is this seasonal employment?  Yes/No. If yes, give dates \_\_\_\_\_

Is employee expected to return to job?  Yes/No. If yes, give date \_\_\_\_\_

Is this temporary employment?  Yes/No. If yes, give end date \_\_\_\_\_

### **WEEKLY WORK SCHEDULE if fixed schedule**

Please list typical work schedule i.e. 9a-5p -within the grid below for each day of work client is expected to work:

SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS PER WEEK

**OR**

If client 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:  all that apply: **M T W TH F ST SN**

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 CCAP 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**

\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



Boulder County Child Care Assistance Program (CCAP)  
 515 Coffman Street - Longmont CO 80501  
 3460 N Broadway - Boulder CO 80304  
 Phone: 303.678.6014  
 Imaging Fax: 303.678.6014  
 CCAP Email: [ccap@bouldercounty.org](mailto:ccap@bouldercounty.org)  
 Imaging Email: [imaging@bouldercounty.org](mailto:imaging@bouldercounty.org)





## BOULDER COUNTY CCAP- CHILD VISITATION FORM

This form is required for children requesting CCAP care that have visitation with a parent who lives outside your home. Please complete the information below regarding visitation.

Child's name: please list all children in home requesting CCAP care:	Is there a visitation agreement for this child?		Is the visitation agreement court ordered for this child?	
1.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

\*\*\*Please provide copies or any COURT ORDERED VISITATION documents that you have for any child requesting CCAP care. \*\*\*

**VISITATION SCHEDULE:** If you have a visitation agreement and do not have Court Ordered Documentation please complete the Visitation Schedule below for each child that has visitation with a parent outside your home. Note if there are children with different parents outside your home, you must complete a separate schedule sheet for each non-custodial parent to sign.

Child Name		MON	TUES	WED	THUR	FRI	SAT	SUN
1.	MOTHER							
	FATHER							
2.	MOTHER							
	FATHER							
3.	MOTHER							
	FATHER							
4.	MOTHER							
	FATHER							

Please include any other information about your visitation schedule that is more specific (ie. Variable schedule, rotating schedule, every other week, etc.)

\_\_\_\_\_  
CCAP Parent Signature/ Date

\_\_\_\_\_  
Non-Custodial Parent Signature/Date

Please return completed form to Boulder County CCAP at 515 Coffman Avenue, Longmont CO 80501, or email to [ccap@bouldercounty.org](mailto:ccap@bouldercounty.org). Please call 303.678.6014 if you have any questions.



# Colorado Voter Registration Form

Fill out all fields marked with an asterisk (\*). Follow the instructions for other fields. If you do not provide all of the required information, your application to register to vote will not be complete.

## For office use only

Voter ID Number: \_\_\_\_\_

Date Stamp: \_\_\_\_\_

### Your eligibility to vote

Are you a citizen of the United States?\* Yes  No

Will you be at least 18 years of age on or before the next Election Day?\* Yes  No

If you answered "No" to either of the above questions, do not complete this form.

### Your name

Last name\*

First name\*

Middle name

If you are currently registered to vote with a different name, what is that name? \_\_\_\_\_

### Your identifying information

Your birthdate\* (MM/DD/YYYY)

Your gender

Female

Male

### You must select one of the following and provide the requested information\*

I have a valid Colorado Driver's License or Colorado ID card (issued by the Dept. of Revenue) and that number is  -  -

I have not been issued a Colorado Driver's License or ID card, but I have a Social Security Number & the last 4 digits are  -  -

I do not have a Colorado Driver's License, ID card, or a Social Security Number.

### Your contact information

#### Your home address

Street address (No P.O. Boxes)\*

Apt. or Unit

City or Town\*

ZIP Code\*

Colorado County

When did you move to this address?\* (MM/DD/YYYY)

#### Address where you receive your mail (required if different from your home address)

Mailing address

Apt. or Unit

City or Town

State

ZIP Code

#### Your former address

If you are changing your registration to a new address, you must provide the address where you were formerly registered to vote.

Street address (No P.O. Boxes)

Apt. or Unit

City or Town

State

ZIP Code

#### Your phone number and email

Area code

Phone number

Email address

### Select or change your political party affiliation

Select only one. (Required if you want to vote in a party's Primary Election or participate in a party caucus).

American Constitution

Americans Elect

Democratic

Green

Libertarian

Republican

Unaffiliated

### Voting by mail - Do you wish to be designated as a permanent mail-in voter?

Yes, I want to be a permanent mail-in voter and automatically receive a mail-in ballot for all applicable elections.

No, I do not want to be a permanent mail-in voter and if my name is on the permanent mail-in list I want it removed.

No, but I would like a mail-in ballot for this year's statewide elections.

If you want mail-in ballots only for certain elections or have different mailing addresses during certain times of the year, you will need to fill out a separate Mail-in Ballot Application.

### Helping with elections

I would like to be an election judge or poll worker. Yes  No

### Sign or mark below

**WARNING:** It is a crime to swear or affirm falsely as to your qualifications to register to vote.

A violation of the self-affirmation, of which you are about to make, is a criminal act under Colorado law and you will be subject to the penalties provided by law.

**Self-Affirmation:** I do solemnly affirm that I am a citizen of the United States and that on the date of the next election I shall have attained the age of eighteen years and shall have resided in the state of Colorado at least 30 days and in my present precinct at least 30 days before the election. I further affirm that the present address I listed herein is my sole legal place of residence and that I claim no other place as my legal residence. I am aware that I can only legally vote in one place in any election and if I register to vote in Colorado I am also considered a resident of Colorado for income tax and motor vehicle registration and operation.

Sign here 

Signature or Mark\*

Date\*

Witness Signature

Date

(If you are registering for a Mail-in Ballot and are unable to sign, you must make a mark and a witness to the mark must sign here).

## Information about this registration

### How do I turn in this form?

Sign the form. Then mail, deliver, or scan the signed form and email it to your county clerk and recorder. You may find a list with contact information at [www.elections.colorado.gov](http://www.elections.colorado.gov).

You may also mail it to

Colorado Department of State  
Elections Division  
1700 Broadway, Suite 200  
Denver, CO 80290

### If I don't know my Colorado driver's license or Colorado ID card number may I provide my Social Security Number instead?

No. If you have a Colorado Driver's License or ID card issued by the Colorado Department of Revenue, you must provide that number for your application to be complete.

### How will I know if my registration was processed?

You will receive an official information card from your county clerk and recorder's office approximately 20 days after they receive your registration form.

You may also check your status at the Colorado Secretary of State website by visiting [www.sos.state.co.us](http://www.sos.state.co.us), clicking on the "verify/update my voter registration" link.

### Am I eligible to register to vote?

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

### Who should I contact if I have more questions?

Contact your county clerk and recorder. You may find a list with contact information at [www.elections.colorado.gov](http://www.elections.colorado.gov).

You may also contact the Secretary of State's office

Phone: 303-894-2200 ext. 6307  
Fax: 303-869-4861  
Email: [State.ElectionDivision@sos.state.co.us](mailto:State.ElectionDivision@sos.state.co.us)

## Other frequently asked questions about registering and voting

### Will I need identification to vote?

If you vote in person, yes. If you are voting by mail for the first time, you may need to provide a photocopy of your ID.

A complete list of acceptable forms of identification is at the bottom of this page.

### When is the last day to register to vote?

29 days before an election.

### What is mail-in voting?

If you choose not go to the polls on Election Day, you may apply to vote by mail-in ballot.

Under Colorado law, your Mail-in Ballot Application must contain your printed name, signature, residence address, mailing address if you wish to receive the ballot by mail, and date of birth. If you do not provide all of this information, you may not receive a mail-in ballot according to the rules established by the Secretary of State. [Section 1-8-104(6), C.R.S.]

### What is permanent mail-in voting?

If you choose to be placed on the list of permanent mail-in voters, you will receive a mail-in ballot for every applicable election. Alternatively, you may ask for a mail-in ballot for a specific election or the calendar year.

### What is the deadline for requesting a mail-in ballot?

If you want a mail-in ballot sent to you by mail, your county clerk and recorder must receive your application no later than the close of business on the 7th day before the election. If you want to pick up your mail-in ballot, you must apply no later than the Friday preceding the election. If you mail your application, make sure to allow time for delivery.

### May I register to vote if I was arrested for or convicted of a crime?

Yes, if you

- are on probation for either a misdemeanor or felony
- are a pretrial detainee awaiting trial
- are currently in jail serving a misdemeanor sentence only
- have served your sentence for a felony conviction, including any period of parole

Once you have served your complete sentence, you are automatically eligible to register to vote. If you were previously registered, that registration will have been canceled and you must re-register if you wish to vote.

## Acceptable forms of identification when voting

If your form of identification shows your address, that address must be in the state of Colorado.

- a valid Colorado driver's license
- a valid identification card issued by the Department of Revenue in accordance with the requirements of Part 3 of Article 2 of Title 42, C.R.S.
- a valid U.S. passport
- a valid employee identification card with a photograph of the eligible elector issued by any branch, department, agency, or entity of the United States government or of this state, or by any county, municipality, board, authority, or other political subdivision of this state
- a valid pilot's license issued by the Federal Aviation Administration or other authorized agency of the United States
- a valid U.S. military identification card with a photograph of the eligible elector
- a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the elector. For examples, please visit: [www.elections.colorado.gov](http://www.elections.colorado.gov)
- a valid Medicare or Medicaid card issued by the Centers for Medicare and Medicaid Services
- a certified copy of a U.S. birth certificate for the elector issued in the United States
- certified documentation of naturalization
- a valid student identification card with a photograph of the eligible elector issued by an institute of higher education in Colorado, as defined in section 23-3.1-102(5), C.R.S.
- A valid veteran identification card issued by the United States department of veterans affairs veterans health administration with a photograph of the eligible elector.
- A valid identification card issued by a federally recognized tribal government certifying tribal membership.