



Boulder County Child Care Assistance Program (CCAP)

How to submit in-person:

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

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

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

CCAP Parents or Adults Caretaker Please Note:

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

SS# _____ CCAP Client’s Name: _____

Current Provider: _____

End Date w/Current Provider: _____

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

New Provider License Number: _____ Start Date w/New Provider: _____

Phone: _____ Fax: _____

For School Age Children:

School Start/End Date: _____
(circle one)

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

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

CCAP Client Signature: _____ Date: _____



Boulder County Change of CCAP Care Request form

Child's Name: _____

CCAP Provider Name: _____

Provider Address: _____ Provider ID: _____ (Mandatory)

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

County Use only: child's age at time of application: _____ Care level at time of application: _____

Additional Child's Name: _____

CCAP Provider Name: _____

Provider Address: _____ Provider ID: _____ (Mandatory)

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

County Use only: child's age at time of application: _____ Care level at time of application: _____

Additional Child's Name: _____

CCAP Provider Name: _____

Provider Address: _____ Provider ID: _____ (Mandatory)

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

County Use only: child's age at time of application: _____ Care level at time of application: _____

Copy this page as needed for additional child schedules.