BOULDER COUNTY CCAP RE-DETERMINATION

******ATTENTION******

Your COMPLETED Re-determination packet

is DUE by the 15th of your redetermination month!

Please do not turn in before your redetermination month begins.

*****All pay stubs received in the last 30 days from the month <u>prior to your redetermination month</u> are due with your re-determination packet.*****

<u>Please note CCAP has 10 days to process the paperwork from the date it is received by CCAP.</u>

You risk a *<u>BREAK IN CARE</u>* if the packet is received after the 15th, if packet is NOT complete or if verifications are missing.

<u>Please pay close attention to all requested information listed on next page as there have been changes.</u>

BOULDER COUNTY CCAP RE-DETERMINATION VERIFICATIONS

It is time to complete your 12-month re-determination. Please complete the attached packet and include the following items:

- **Income verification:** Please submit copies of all pay stubs received in the last 30 days from the month prior to redetermination. If you have recently started new employment (less than 60 days) please submit the Verification of Employment Form showing your estimated income (date of hire, date of first paycheck, rate of pay, total hours scheduled per week, if taxes are taken out and pay periods).
    - If you are self-employed you must submit a self-employment ledger of earnings, hours worked and business expenses for the month prior to your redetermination (copies of receipts for business expenses must be provided in order for expenses to be deducted). If you are an LLC or S-corp, you must inform CCAP that you are an LLC/ S-corp and submit copies of all paystubs received in the last 30 days from the month prior to your redetermination or an owner's draw log or a profit/loss monthly statement showing the company paying out to you.
- **ALL other household income**: Please provide verification of any other household monies received. This includes but not limited to all child support, disability, and armed forces pay.
- **Child support documentation**: If your child support is not through Boulder County and Family Support Registry, you must provide verification of this income. If you are paying out child support, you must provide verification of this income. If you stopped paying out for child support, you must provide verification of when you stopped paying out for child support.
- **Students:** Please provide a copy of current enrollment status. CCAP will accept official copies of class schedules showing dates of enrollment as verification. You name and school attending must be visible on your documentation.
- **Additional household members**: If you have added any new children to your household in which you are requesting care, please provide verification of their citizenship (i.e. Birth certificate, passport. Note: a social security card does not verify citizenship).
- **Verification of County Residency**: Please provide a copy of your most recent lease, mortgage statement, utility bill, current automobile registration. Your name and date must be visible on the verification. If you cannot provide these, you may submit a signed letter from your landlord/roommate stating the address you reside at with their name and phone number and provide verification in the landlord/roommates name. Verification cannot be more than 60 days old.

In addition to the packet please complete the following forms also attached:

- **Client Responsibilities Agreement:** Please read, sign and date.
- **Unrelated Individuals Questionnaire:** Please report any unrelated individuals living in the home not related to you or the child(ren).
- **Child Visitation Form:** You must fill out the days and times that you have the child(ren). CCAP needs to know when you have your child(ren) and when the non-custodial parent has the child(ren). You risk a break in care if you do not complete this form. Court documents can also be used showing current parenting plan.
- **Child Care Request Form:** Please fill out this form in its entirety. This form helps CCAP to identify the kind of care you are requesting. It is important for CCAP to know if you need before and/or after school care, late start days, non-school days or full time summer care. If you require care outside of traditional care hours (6am-6:30pm) then you must provide:
    - **Parent/Adult caretaker work schedules:** Please provide a copy of your work schedule, an employer letter stating work hours or Verification of Employment Form showing your weekly schedule or estimated variable schedule (include total number of hours per week).

Please contact Boulder County CCAP if you have any questions regarding this packet or verifications list. We can be reached via phone at 303.678.6014, via email at ccap@bouldercounty.org or in person during walk in hours Tues/ Thurs 11am-1pm in both Boulder and Longmont offices.

****Please remember yoru completed packet is due by the 15th of the month due. Late redeterminations may result in break in care and no payment made for care used. Additional verification may be requested to re-determine your case. Returned packets are not a guarantee of continued care, once case is worked by a CCAP technician a new authorization will be created for care and sent to you as well as your provider.****

COLORADO DEPARTMENT OF HUMAN SERVICES
CHILD CARE ASSISTANCE PROGRAM

RE-DETERMINATION OF ELIGIBILITY FORM

You received this form so the County Department of Social/Human Services can update your eligibility for child care assistance. Please note that failure to complete a re-determination and to supply required documentation will result in the discontinuation of your child care benefits.

All items marked with an * on this re-determination form MUST be completed.

Please complete and return this form as soon as you receive it. If we do not receive this form and all verification by _____ your child care arrangements will be terminated by _____ [Volume 3, Section 3.921].

Section 1:

Date*: _____

Primary Adult Caretaker Name*: _____ Case #: _____

Residence Address*: _____

Primary Phone*: _____ Secondary Phone: _____

Emergency Contact Name: _____ Phone: _____

Email: _____

Has your residence address changed*? _Yes _No

If Yes, your new residence address is: _____

_____

Do Any of the following apply to your current living situation?	☐ Living in hotel or motel	☐ Living in campground	☐ Living in shelter	☐ Living in substandard housing such as car, park, etc.
	☐ Have a temporary living situation (please explain)		Date living situation began: ____/____/_____ Anticipated end date: ____/____/_____	

Section 2:

☐ **EMPLOYMENT* (include the last thirty (30) days of pay stubs for verification)**

Primary adult caretaker's name*: _____

1. Are you working*?

___ Yes If Yes, where? _____ Phone _____

How often are you paid? _____

___ No If no, when did you stop working (date)? _____

2. Do you have a second job*?

___ Yes If Yes, where? _____ Phone _____

How often are you paid? _____

___ No

3. Do you have a new job*? *(Attach employment verification letter from employer)*

___ Yes If Yes, fill in the following: Start Date _____

___ No Employer's name _____ Phone _____

*Is the new job in addition to the old job? ___ Yes ___ No

4. Are there two adult caretakers in your home*? (If you are a teen parent do not include your parents)
_____ Yes _____ No **If Yes, answer questions 5 - 7**

Second adult caretaker's name*: _____

5. Is he/she working*?

___ Yes If Yes, where? _____ Phone _____

How often are you paid? _____

___ No If no, when did you stop working (date)? _____

6. Does he/she have a second job*?

___ Yes If Yes, where? _____ Phone _____

How often are you paid? _____

___ No

7. Does he/she have a new job*? *(Attach employment verification letter from employer)*

___ Yes If Yes, fill in the following: Start Date _____

___ No Employer's name _____ Phone _____

*Is the new job in addition to the old job? ___ Yes ___ No

Section 3:

☐ **EDUCATION/TRAINING***

Primary adult caretaker name*: _____

8. Are you in training*? _____ Yes _____ No Where? _____

Are you in school*? _____ Yes _____ No Where? _____

Second adult caretaker name* (If applicable): _____

9. Are you in training*? _____ Yes _____ No Where? _____

Are you in school*? _____ Yes _____ No Where? _____

Section 4:

☐ **JOB SEARCH/DISABILITY***

*Primary adult caretaker name: _____

10. Are you looking for a job*? _____ Yes _____ No If yes, start date?_____

Are you disabled*? _____ Yes _____ No If yes, start date?_____

If yes, is the disability _____permanent or _____temporary? If temporary, end date? _____

Are you on m/paternity leave*? _____ Yes _____ No If yes, start date?_____

If yes, expected end date? _____

Second adult caretaker name* (If applicable): _____

11. Is he/she looking for a job*? ____ Yes _____ No If yes, start date?_____

Is he/she disabled*? _____ Yes _____ No If yes, start date?_____

If yes, is the disability _____permanent or _____temporary? If temporary, end date? _____

Is he/she on m/paternity leave*? _____ Yes _____ No If yes, start date?_____

If yes, expected end date? _____

Section 5:

☐ **HOUSEHOLD INFORMATION***

List ALL people in your household:

Last Name, First Name, Middle Initial*	How related to you*?	Gender* M/F	Date of Birth*	Children's Immunization information*: (codes below)
	SELF			

Immunization record codes: **IM**: Child Immunized **ME**: Medical Exemption **RE**: Religious Exemption **OT**: Other (explain)

Are any of the people listed above new to your household*? ____Yes ____ No
If yes, complete the following information:

☐ **Newly added adults* (If applicable) use additional paper if necessary and include all requested information**

Date Entered Home*	Last Name, First Name*	Social Security Number (optional)	Military Status	Marital Status (see codes below)	Hispanic or Latino (Y/N)	Race(s) List all that apply, (see codes below)
			☐ Active Military (serving full time) ☐ Military Reserves ☐ National Guard			
			☐ Active Military (serving full time) ☐ Military Reserves ☐ National Guard			

Race codes (use all that apply): **A**-Asian, **B**-Black/African American, **H**- Hispanic I: American Indian/Alaska Native P-Native Hawaiian/Other Pacific Islander, **W**-White
Marital Status Codes: **D**-Divorced, **M**-Married, **S**-Single, **P**-Separated, **W**-Widowed

☐ **Newly added dependents/children* (If applicable)**

Date Entered Home*	Last Name, First Name*	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child*? (Y/N)	Disabled child*? (Y/N)	Date of Birth*	Immunization information*: (codes below)
If this 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 this 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
Name of Parent(s) outside of household who may have duty for child support: **Last:** _____ **First:** _____								
Date Entered Home*	Last Name, First Name*	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child*? (Y/N)	Disabled child*? (Y/N)	Date of Birth*	Immunization information*: (codes below)
If this 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 this 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
Name of Parent(s) outside of household who may have duty for child support: **Last:** _____ **First:** _____								
Date Entered Home*	Last Name, First Name*	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child*? (Y/N)	Disabled child*? (Y/N)	Date of Birth*	Immunization information*: (codes below)
If this 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 this 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
Name of Parent(s) outside of household who may have duty for child support: **Last:** _____ **First:** _____								

Race codes (use all that apply):, **A**-Asian, **B**-Black/African American, **H**- Hispanic **I**: American Indian/Alaska Native **P**-Native Hawaiian/Other Pacific Islander, **W**-White

Immunization record codes **IM**: Child Immunized **ME**: Medical Exemption **RE**: Religious Exemption **OT**: Other (explain)

☐ **Are any of the children listed above not U.S. citizens*? ___ Yes ___ No** If yes, please provide the following:

Child's name*	Date of Birth*	Alien Registration Information*
		A
		A

☐ **Are any of the children listed above a part of a Joint Custody or Foster Custody Arrangement?**
___ Yes ___ No If yes, please provide the following:

Child's name*	Joint Custody or Foster Custody?	Date Moved into custody arrangement
	☐Joint Custody ☐ Foster Custody	
	☐Joint Custody ☐ Foster Custody	

☐ **Has anyone left your household*?** ___ **Yes** ___ **No** If yes, please provide the following:

Name*	Date left*	Reason for Leaving*

Section 6:

☐ **Other Benefit Program Information**

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

Section 7:

☐ **EMPLOYMENT OR EDUCATION/TRAINING SCHEDULE(S)***

Please fill in your employment or education/training schedule. If there are two adult caretakers in your household, fill in schedules for both adult caretakers. If you have more than one job, please be sure to include schedules for all employment.

Example: Schedule: Hours:	*Mon. (am/pm)* *8:00 - 5:00* *9*	*Tues. (am/pm)* *8:00 - 3:00* *7*	*Weds. (am/pm)* *8:00 - 5:00* *9*	*Thurs. (am/pm)* *8:00 - 3:00* *7*	*Fri. (am/pm)* *8:00 - 5:00* *9*	*Sat.* *0* *0*	*Sun.* *0* *0*
MY SCHEDULE*	**Mon.**	**Tues.**	**Weds.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
Work*							
# Hours*							
Education/Training*							
# Hours*							
2ND ADULT CARETAKER*	**Mon.**	**Tues.**	**Weds.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
Work*							
# Hours*							
Education/Training*							
# Hours*							

If your schedule varies please explain: _____

Section 8:

☐ **CHILDREN'S SCHEDULE(S)***

Please fill in each child's schedule. Please indicate when you plan to have your child in care each day for each provider used (if more than one). Note that care will be approved based on eligibility and please attach a copy of each school-aged child's school calendar/schedule.

Child's Name*:						Effective Begin Date*:	Effective End Date:
Provider Name and License #*:							
Provider Address*:							
Example: Schedule: Hours:	*Mon. (am/pm)* *8:00 - 5:00* *9*	*Tues. (am/pm)* *8:00 - 3:00* *7*	*Weds. (am/pm)* *8:00 - 5:00* *9*	*Thurs. (am/pm)* *8:00 - 3:00* *7*	*Fri. (am/pm)* *8:00 - 5:00* *9*	*Sat.* *0* *0*	*Sun.* *0* *0*
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule*							
# Hours*							

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: ___/___/_____

☐ **CHILDREN'S SCHEDULE(S)***

Please fill in each child's schedule. Please indicate when you plan to have your child in care each day for each provider used (if more than one). Note that care will be approved based on eligibility and please attach a copy of each school-aged child's school calendar/schedule.

Child's Name*:						Effective Begin Date*:	Effective End Date:
Provider Name and License #*:							
Provider Address*:							
Example: Schedule: Hours:	*Mon. (am/pm)* *8:00 - 5:00* *9*	*Tues. (am/pm)* *8:00 - 3:00* *7*	*Weds. (am/pm)* *8:00 - 5:00* *9*	*Thurs. (am/pm)* *8:00 - 3:00* *7*	*Fri. (am/pm)* *8:00 - 5:00* *9*	*Sat.* *0* *0*	*Sun.* *0* *0*
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule*							
# Hours*							

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: ___/___/_____

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILD SCHEDULES.

Page _____ of _____

Section 9:

☐ **INCOME QUESTIONS*: List *ALL* income. If there is no income enter a zero.**

Fill in your total family income per month*:

Income Type	My Income	2nd Adult caretaker Income	Income Type	My Income	2nd Adult caretaker Income
Wages (before taxes)*	$	$	Social Security survivor's benefits, permanent disability insurance payments*	$	$
Self-employed income*	$	$	Lease bonuses & royalties*	$	$
Tips or _____ % Commission	$	$	Military allotments*	$	$
Child Support*	$	$	Strike benefits*	$	$
Alimony Payment*	$	$	Dividends, interest, income from estates or trusts, net rental income, royalties*	$	$
Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	$	$	Retirement and pension payments* (Veteran's, Social Security pensions)	$	$
Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	$	$	Unemployment insurance*	$	$
Worker's compensation*	$	$	Other income*	$	$
			TOTAL INCOME*	$	$
			TOTAL FAMILY INCOME*	$	

☐ **OTHER INCOME* (If applicable) Do you or anyone in your household receive any of the following income? If Yes, please complete the table below.**

1. Housing voucher or cash assistance	☐ Yes ☐ No	2. Food stamp assistance	☐ Yes ☐ No ☐ No, I would like to apply	3. Refugee cash assistance or medical assistance	☐ Yes ☐ No
4. Colorado Works/ TANF cash assistance	☐ Yes ☐ No	5. Supplemental Security Income (SSI)	☐ Yes ☐ No	6. Low-income energy assistance (LEAP)	☐ Yes ☐ No
7. Old age pension	☐ Yes ☐ No	8. Americorp Income	☐ Yes ☐ No		

Name of person receiving income*	Type of income (use number from above)*	How often received*? (Monthly, weekly, etc.)

Other changes or comments you want to make:

_____

_____

_____

Authorization to Supply Information

I hereby authorize the _____ County Department of Social 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 child care 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 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 child care assistance programs including Head Start and Early Head Start.

☒Signature of Client: _____ Date: _____

☒Signature of Spouse and/or Other Adult Caretaker:_____Date:_____

YOU MUST READ AND SIGN THIS PAGE

You must submit the following documentation with this form:

IF YOU ARE WORKING YOU NEED TO INCLUDE:

- For self-employed persons, a business ledger and copies of your total business earnings, your business expenditures for the last thirty (30) days, and your expected work schedule. (Please be aware that you must make a profit and you must meet the current Federal Minimum wage to remain eligible.)

- Income verification and verification of the work schedule. You must attach copies of all household members' **pay stubs from the last thirty (30) days.** Please be aware that you must meet the current Federal Minimum Wage to remain eligible.

If you just started a new job, you must provide a completed copy of the employment verification letter including: your start date, your wages, your schedule, number of hours/days you work per week, how often you will be paid, and the date of your first paycheck.

If you lose your job and need child care assistance while looking for work, Job Search Child Care is available on a LIMITED basis and you must have prior approval to use child care services for Job Search.

IF YOU ARE REQUESTING CARE FOR EDUCATION/TRAINING, YOU NEED TO INCLUDE:

- A letter from your education/training institution which
  (1) Verifies you are enrolled and making satisfactory progress.
  (2) Identifies the program you are enrolled in, and
  (3) Identifies when you are expected to complete the program.
  (4) Start and end dates of quarter, semester, or session;
  (5) Days/time of class and
  (6) Number of credits.

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.

Completion Checklist Did you:					
	Complete Re-determination		Attach required pay stubs		Attach employment verification letter (if new employment)
	Sign and date Re-determination		Attach all training information		Attach verification of any other income
	Attach work or education/training schedule		Attach all education information		

I certify that the information on this form is correct, to the best of my knowledge. I understand that failure to report 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

☒ _____ _____ _____

Primary Adult Caretaker Signature **Daytime Phone** **Date**

☒ _____ _____ _____

Other Adult Caretaker Signature **Daytime Phone** **Date**

IMPORTANT REMINDERS:

A person found to have intentionally given false information by deed or omission cannot get child care assistance in Colorado 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.

You must report changes to income where the total income exceeds eighty-five per cent (85%) of the State Median Income, in writing, within ten (10) calendar days of the change. You must also report if you are no longer in your eligible activity, in writing, within four (4) calendar weeks.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social/human services.

Until you are approved for the Child Care Assistance Program you are responsible for the cost of child care. Please ask your eligibility worker for details.

After you are approved for the Child Care Assistance Program you are responsible for payment of Parental Fees (if applicable) to your Provider. Please ask your eligibility worker for details.

To remain eligible for the Child Care Assistance Program you are responsible for providing all required information to complete your re-determination. Please ask your eligibility worker for details.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social/human services.

Until you are re-determined as eligible for the Child Care Assistance Program you are responsible for the cost of child care.

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
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

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 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)

4. I agree to notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.

5. I agree to be responsible for resolving any problems I might have with my child care provider.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. I understand that if new CCAP cards are issued to me, I must report non-receipt of the cards within five (5) business days.

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. PARENT FEE:
    a. 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.
    b. 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.
    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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UNRELATED INDIVIDUALS QUESTIONAIRRE

Participant Name: _____ **Case#:**_____

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.

IS THERE ANYONE LIVING IN YOUR HOUSEHOLD WHO IS NOT RELATED TO YOU OR YOUR CHILD (REN)?

☐ YES. Name of Individual: _____. Please answer all questions in sections A and B below.

☐ NO. Please skip ahead to section C.

A. **Financial Assistance:** Does the unrelated individual living in your home provided any of the following to you or your child (ren):

Routinely pays medical bills for any member of your family	YES ☐ NO☐
Provides health insurance for any member of your family	YES ☐ NO☐
Allows you to use their debit or credit cards	YES ☐ NO☐
Maintains a joint bank account with anyone in your family	YES ☐ NO☐
Owns /buying a motor vehicle jointly with any member of your family	YES ☐ NO☐
Owns/ buying real estate, including your home, with nay member of your family	YES ☐ NO☐
Pays 100% of the shelter/utility costs for you and your family	YES ☐ NO☐

B. **Parenting:** Does the unrelated individual living in your home provided daily decision-making and guidance for your child (ren):

Routinely purchase clothing for your child(ren)	YES ☐ NO☐
Pays fees for school activities/ tuition	YES ☐ NO☐
Decides your child(ren)'s future about schooling/religion	YES ☐ NO☐
Provides discipline to child (ren)	YES ☐ NO☐
Routinely helps with homework/projects	YES ☐ NO☐
Attends school activities/ conferences	YES ☐ NO☐
Is recognized at school, child care or doctor's office as being able to sign in your place	YES ☐ NO☐
Makes decisions about daily living activities such as bedtime, clothing, social activities	YES ☐ NO☐

C. I attest that the above information is true and correct.

Participant Sign_____ Date_____

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 ☐	No ☐	Yes ☐	No ☐
2.	Yes ☐	No ☐	Yes ☐	No ☐
3.	Yes ☐	No ☐	Yes ☐	No ☐
4.	Yes ☐	No ☐	Yes ☐	No ☐

***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 St., Longmont CO 80501, or email to ccap@bouldercounty.org. Please call 303.678.6014 if you have any questions.

Boulder County Child Care Assistance Program (CCAP)

Child Care Request Form

3460 N. Broadway, Boulder, CO. 80304

515 Coffman St, Longmont, CO 80501

E-mail: ccap@bouldercounty.org call: 303.678.6014

BOULDER COUNTY HOUSING & HUMAN SERVICES

CCAP Client's Name: _____ Date: _____

Child Care Needed:

	Child Name	Child Name	Child Name	Child Name
CARE needed	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
School Aged:	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Type of care	FT ☐ PT ☐	FT ☐ PT ☐	FT ☐ PT ☐	FT ☐ PT ☐
School Aged only:	BEFORE ONLY ☐ AFTER ONLY ☐ B/A☐ FT NON-SCHOOL DAYS ☐ FT SUMMER ☐	BEFORE ONLY ☐ AFTER ONLY ☐ B/A☐ FT NON-SCHOOL DAYS ☐ FT SUMMER ☐	BEFORE ONLY ☐ AFTER ONLY ☐ B/A☐ FT NON-SCHOOL DAYS ☐ FT SUMMER ☐	BEFORE ONLY ☐ AFTER ONLY ☐ B/A☐ FT NON-SCHOOL DAYS ☐ FT SUMMER ☐

*****Please complete a schedule for each child at each provider location.*****

Child Name:_____

CCAP Provider Name: _____ Location or Provider ID# (required): _____

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

Child Name:_____

CCAP Provider Name: _____ Location or Provider ID# (required): _____

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

Child Name:_____

CCAP Provider Name: _____ Location or Provider ID# (required): _____

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

Child Name:_____

CCAP Provider Name: _____ Location or Provider ID# (required): _____

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# hours							

Copy this page as needed for additional child schedules.

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? Circle Yes/No. If yes, give dates _____
Is employee expected to return to job? Circle Yes/No. If yes, give date _____
Is this temporary employment? Circle 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: Circle 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 HOUSING & HUMAN SERVICES
Hope for the future, help when you need it.

Boulder County

CCAP BOULDER COUNTY

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
Imaging Email: Imaging@bouldercounty.org