

Completion of this application does not guarantee that you will receive child care assistance.
 All eligibility criteria must be met for you to qualify and receive assistance.

Application for Child Care Services

Completion of this application does not guarantee that you will receive child care assistance.

- All eligibility criteria must be met for you to qualify and receive assistance.
- Please provide all requested information (see Page 17 for additional information you must provide). Missing information will delay your application. * =required information

Teen Parents: Do not include information about your parents even if you live with them.

Section 1: Applicant Information			If you are not the parent of Child for whom you are applying, are you the Primary Adult Caretaker*?		
All Items Marked with (*) on this application MUST be completed			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Application Date*:			Are there other Adult Caretaker(s) in the household?		
Last Name*:			First name*:		Middle Initial:
Residence Address*:			Mailing Address*: <input type="checkbox"/> Same as residence ?		
City*:	State:	Zip*:	City*:	State:	Zip*:
County*:			County*:		
What language do you prefer to use?			County Use Only		
			Address Verified? How Verified?		
Contact Information: <i>Please complete at least one of these</i>		Home Phone: () Best Time to Call:	Work Phone: () Ext Best Time to Call:	Mobile Phone: () Best Time to Call:	
Email Address:		Emergency Contact Number: () Ext		Emergency Contact Name (Required with #):	
Preferred Method of Contact Listed*: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mail <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Email					
Other Information:					
Mark below regarding the benefits your household may be receiving:					
Housing Assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No If No, would you like to receive Food Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	LEAP / SSI / OAP / Refugee Medical Assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No

You **MUST** answer all **YES or NO** questions, sign and date this form.
Any question answered with N/A will be considered incomplete and may delay application processing

Section 2: Primary Adult Caretaker (same as Applicant, Section 1)				
Last Name*:		First Name*:		Middle Initial:
Social Security Number (optional):				
Date of Birth*:		Age:		
		County Use Only		
		Birthdate Verified: Not Available Pending Verbal Written		
		How Verified?		
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		County Use Only		
		Identity Verified: Not Available Pending Verbal Written		
		How Verified?		
Citizenship Status*:		County Use Only		
<input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien		Citizenship Verified: Not Available Pending Verbal Written		
		How Verified?		
Marital Status:				
<input type="checkbox"/> Divorced <input type="checkbox"/> Married, Living w/Spouse <input type="checkbox"/> Married, Not Living w/Spouse (involuntarily)				
<input type="checkbox"/> Married, Not Living w/Spouse (voluntarily) <input type="checkbox"/> Significant Other <input type="checkbox"/> Single – Never Married <input type="checkbox"/> Widowed/Widower				
Ethnicity (optional):		Race (optional, all that apply):		
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian		
		<input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian or Pacific Islander		
Highest Grade Completed: <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown				
What ACTIVITY will you be in while your child is in care?* (Check all that apply to you)				
<input type="checkbox"/> Disabled, unable to care for child	<input type="checkbox"/> GED/High School Diploma	<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	
<input type="checkbox"/> Elementary School	<input type="checkbox"/> Teen Parent Education	<input type="checkbox"/> Job Search	<input type="checkbox"/> Other Income (Non-work income)	
<input type="checkbox"/> Training/Education	<input type="checkbox"/> Post-Secondary School	<input type="checkbox"/> Middle / Jr. High	<input type="checkbox"/> English as a second language	
Do You?				
<input type="checkbox"/> Pay Child Support				
<input type="checkbox"/> Receive Child Support				

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing

Section 3: Additional Individual in your Household (Adult or Child)

Complete Section 3 for every adult and child in your Household

Last Name*:		First Name*:		Middle Initial:	
Date of Birth*:		Age:		County Use Only	
Social Security Number (optional):		Verified:		Not Available	Pending
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		How Verified?			
Citizenship Status*:					
<input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien					

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

Ethnicity (optional):	Race (optional, all that apply):
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	<input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian or Pacific Islander

Highest Grade Completed: Associate Degree Bachelor Degree Graduate Degree Other _____ Unknown

ACTIVITY* Check all that apply to this individual

<input type="checkbox"/> Disabled	<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> GED/High School Diploma
<input type="checkbox"/> Elementary School	<input type="checkbox"/> Teen Parent Education	<input type="checkbox"/> Job Search	<input type="checkbox"/> Other Income (Non-work income)
<input type="checkbox"/> Training/Education	<input type="checkbox"/> Post-Secondary School	<input type="checkbox"/> Middle / Jr. High	<input type="checkbox"/> English as a second language
		<input type="checkbox"/> Pays Child Support	<input type="checkbox"/> Receives Child Support

Section 3A: Additional Individual in your Household (Adult or Child), if applicable

Last Name*:		First Name*:		Middle Initial:	
Date of Birth*:		Age:		County Use Only	
Social Security Number (optional):		Verified:		Not Available	Pending
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		How Verified?			
Citizenship Status*:					
<input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien					

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

Ethnicity (optional):	Race (optional, all that apply):
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	<input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian or Pacific Islander

Highest Grade Completed: Associate Degree Bachelor Degree Graduate Degree Other _____ Unknown

ACTIVITY* (Check all that apply to this individual)

<input type="checkbox"/> Disabled	<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> GED/High School Diploma
<input type="checkbox"/> Elementary School	<input type="checkbox"/> Teen Parent Education	<input type="checkbox"/> Job Search	<input type="checkbox"/> Other Income (Non-work income)
<input type="checkbox"/> Training/Education	<input type="checkbox"/> Post-Secondary School	<input type="checkbox"/> Middle / Jr. High	<input type="checkbox"/> English as a second language
		<input type="checkbox"/> Pays Child Support	<input type="checkbox"/> Receives Child Support

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS Page _____ of _____

You **MUST** answer all **YES or NO** questions, sign and date this form.
Any question answered with N/A will be considered incomplete and may delay application processing

Section 4: Relationship Detail* Complete for all individuals listed in Sections 2 and 3		
Primary Adult Caretaker Name:		
List all Individuals in the Household:	What is the Relationship to the Primary Adult Caretaker?	Is this a child who is part of a Joint Custody agreement or another case?
		<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
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
County Use Only		
Verification:		

Section 5: Children’s Care Request and Immunization Records* (Complete for all children listed in Section 3)				
	Are You Requesting Care for this Child?	If you are requesting care, does this child have age-appropriate immunizations?	County Use Only	
			Verified?	How Verified
Child Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Immunized <input type="checkbox"/> NO, In Process <input type="checkbox"/> NO, Religious Reason <input type="checkbox"/> NO, Medical Reason	Not available Pending Verbal Verification Written Verification	Dr/Nurse statement Provider School Age Shot Record
Child Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Immunized <input type="checkbox"/> NO, In Process <input type="checkbox"/> NO, Religious Reason <input type="checkbox"/> NO, Medical Reason	Not available Pending Verbal Verification Written Verification	Dr/Nurse statement Provider School Age Shot Record
Child Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Immunized <input type="checkbox"/> NO, In Process <input type="checkbox"/> NO, Religious Reason <input type="checkbox"/> NO, Medical Reason	Not available Pending Verbal Verification Written Verification	Dr/Nurse statement Provider School Age Shot Record
Child Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Immunized <input type="checkbox"/> NO, In Process <input type="checkbox"/> NO, Religious Reason <input type="checkbox"/> NO, Medical Reason	Not available Pending Verbal Verification Written Verification	Dr/Nurse statement Provider School Age Shot Record
Child Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Immunized <input type="checkbox"/> NO, In Process <input type="checkbox"/> NO, Religious Reason <input type="checkbox"/> NO, Medical Reason	Not available Pending Verbal Verification Written Verification	Dr/Nurse statement Provider School Age Shot Record

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing

Section 6: Applicant Employment and Wage Detail Information: Complete Section 6 for <u>each employed adult and each place of employment in your household</u> - Adults in Section 3. Includes employment through CO WORKS and CO HIRE							
Applicant Name*:			Employment Begin Date*:		Employment End Date:		
Are you the Primary Adult Caretaker? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you Self- Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill out Self-Employment Expenses Section 8				
Employer Name*:					Doing Business As:		
Employer Address:			City*:		State:		ZIP:
How frequently are you paid**?			Is this a New Job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, first Pay Date:		# Hours Worked*:	Tips/Commissions/ Bonuses: \$	Gross Amount Before Taxes and Deductions*: \$
<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> 2 times per month <input type="checkbox"/> Every two months <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually <input type="checkbox"/> One Time							
County Use Only	Pay Date*	Frequency*	Hours Worked*	Hours Care Needed	Calculated Pay Rate Per Hour:	Tips/Commissions/ Bonuses:	Gross Amount Before Taxes and Deductions*:
Verification Type*							
Do you expect any breaks in your employment:							
Maternity Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No Leave Begin Date: _____ Date Returning: _____							
School Break/Temporary Layoff / Strike? <input type="checkbox"/> Yes <input type="checkbox"/> No Break Begin Date: _____ Break End Date: _____							

Applicant Work Schedule Complete this section for each adult in the household in Sections 2 and 3 that is marked "Employed or Self-Employed" in Activity							
Name*:					Effective Begin Date*:		Effective End Date:
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
County Use Only	Verified? Not Available Pending Verbal Written					How Verified?	

You **MUST** answer all **YES or NO** questions, sign and date this form.
 Any question answered with N/A will be considered incomplete and may delay application processing

Section 6A: Additional Adult Caretaker Employment and Wage Information, if applicable

Name*:		Employment Begin Date*:		Employment End Date:			
		Is This Individual Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in Self-Employment Expenses Section 8					
Employer Name*:				Doing Business As:			
Employer Address:			City*:		State*:	ZIP:	
How frequently is this individual paid*?		Is This a New Job?		# Hours Worked*:	Tips/Commissions / Bonuses:	Gross Amount Before Taxes and Deductions*:	
<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	\$	
<input type="checkbox"/> Monthly	<input type="checkbox"/> Every 2 weeks	If yes, first Pay Date:					
<input type="checkbox"/> 2 times per month	<input type="checkbox"/> Every two months	Is this temporary or Seasonal?		Per:	Per:	Per:	
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-annually	<input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Annually	<input type="checkbox"/> One Time	Estimated End Date:					
County Use Only Verification Type	Pay Date*	Frequency*	Hours Worked*	Hours Care Needed	Rate Per Hour:	Tips/Commissions / Bonuses:	Gross Amount Before Taxes and Deductions*:
Do you expect any breaks in your employment:							
Maternity Leave?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leave Begin Date: _____		Date Returning: _____	
School Break/Temporary Layoff / Strike?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Break Begin Date: _____		Break End Date: _____	

Additional Adult Work Schedule, if applicable Complete Section 6A for each adult in your household in Sections 2 and 3 that is marked "Employed or Self-Employed" in Activity

Individual*:					Effective Begin Date*:		Effective End Date:	
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
Schedule								
# Hours								
County Use Only	Verified?	Not Available	Pending	Verbal	Written	How Verified?		

COPY THIS PAGE AS NEEDED FOR ADDITIONAL ADULT CARETAKERS AND/OR MULTIPLE EMPLOYERS
 Page _____ of _____

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing

Section 7: Other Income, if applicable Complete information in Section 7 for <u>each person</u> in your household with "Other Income" in Activity or a "Yes" answer in the Types below			
Individual Name:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Non-Work Income Types: Refugee Cash Assistance Social Security (Survivor's, Disability, Retired) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Dividends from stocks and bonds Railroad Retirement Benefits Veteran's Benefits	<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 <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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income Americorp Income Worker's Compensation	<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 <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
Other Income Types: Housing voucher or cash assistance Colorado Works/TANF cash assistance Low-Income Energy Assistance (LEAP) Supplemental Security Income (SSI)	<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	Refugee Medical Assistance Medicaid/CHP+ Assistance Old Age Pension Food Assistance Other (Describe under Individual)	<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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Name:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Non-Work Income Types: Refugee Cash Assistance Social Security (Survivor's, Disability, Retired) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Dividends from stocks and bonds Railroad Retirement Benefits Veteran's Benefits	<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 <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	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income Americorp Income Worker's Compensation	<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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Income Types: Housing voucher or cash assistance Colorado Works/TANF cash assistance Low-Income Energy Assistance (LEAP) Supplemental Security Income (SSI)	<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	Refugee Medical Assistance Medicaid/CHP+ Assistance Old Age Pension Food Assistance Other (Describe under Individual)	<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 <input type="checkbox"/> Yes <input type="checkbox"/> No

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS WITH OTHER INCOME

Page _____ of _____

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing

Section 8: Adult Caretaker Self-Employed Expenses Detail, if applicable (Complete Section 8 for each Adult Caretaker listed in Sections 2 and 3 who is Self-Employed)

Name:			County Use Only	
Expense Date:	Frequency:	Expense Amount:	Verified:	How Verified:
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	

Section 8A: Additional Adult Caretaker Self-Employed Expenses Detail, if applicable

Name:			County Use Only	
Expense Date:	Frequency:	Expense Amount:	Verified:	How Verified:
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	

Section 9: Teen Parent Education Detail, if applicable Complete Section 9 for each Teen Parent listed in Sections 2 and 3 who is marked "Teen Parent Education" in Activity

Name*:			
Number of Credits*:	School Name:	School Type*: <input type="checkbox"/> GED/High School <input type="checkbox"/> Middle School / Jr. High	Anticipated Completion Date:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

Section 9A: Additional Teen Parent Education Detail, if applicable

Name*:			
Number of Credits*:	School Name:	School Type*: <input type="checkbox"/> GED/High School <input type="checkbox"/> Middle School / Jr. High	Anticipated Completion Date:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

You **MUST** answer all **YES or NO** questions, sign and date this form.
 Any question answered with N/A will be considered incomplete and may delay application processing

Section 10: Adult Caretaker Training/Education Detail : (Complete Section 10 for each Adult Caretaker listed in Sections 2 and 3 who marked "Training/Education" in Activity)

Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution:	Type of Training: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> ESL <input type="checkbox"/> Post-Secondary Ed <input type="checkbox"/> GED/HS Diploma <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

Section 10A: Additional Adult Training/Education Detail, if applicable :

Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution:	Type of Training: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> ESL <input type="checkbox"/> Post-Secondary Ed <input type="checkbox"/> GED/HS Diploma <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

Section 11: Adult Caretaker Disability Detail Complete Section 11 for each Adult Caretaker listed in Sections 2 and 3 who marked "Disabled" in Activity

Name*:		Disability Reported Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Review Due Date, if applicable	
Is this Individual able to take care of children*? <input type="checkbox"/> Yes <input type="checkbox"/> No	County Use Only Verified? Not Available Pending Verbal Written	How Verified?	

Section 11A: Additional Adult Caretaker Disability Detail, if applicable

Name*:		Disability Reported Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Review Due Date:	
Is this Individual able to take care of children*? <input type="checkbox"/> Yes <input type="checkbox"/> No	County Use Only Verified? Not Available Pending Verbal Written	How Verified?	

You **MUST** answer all **YES or NO** questions, sign and date this form.
 Any question answered with N/A will be considered incomplete and may delay application processing

Section 12: Child Disability Detail Complete Section 11 for each child in your household in Section 3 who marked "Disabled" in Activity

Name*:		Disability Reported Date*:	Disability End Date:
If Disability requires additional care, please describe:		Intervention Type: <input type="checkbox"/> Level 1 - Low <input type="checkbox"/> Level 2 - Moderate <input type="checkbox"/> Level 3 - High <input type="checkbox"/> Level 4 - Intense	Review Due Date, if applicable
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

Section 12A: Additional Child Disability Detail, if applicable :

Name*:		Disability Reported Date*:	Disability End Date:
Describe Additional Care Needs:		Intervention Type: <input type="checkbox"/> Level 1 - Low <input type="checkbox"/> Level 2 - Moderate <input type="checkbox"/> Level 3 - High <input type="checkbox"/> Level 4 - Intense	Review Due Date:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

Section 13 : Adult Caretaker Paying Child Support Detail Complete this Section for each Adult Caretaker listed in Sections 2 and 3 who marked "Pays Child Support" in Activity

Name*:		Effective Begin Date*:	Effective End Date:
Docket/Court Case #*:	Recipient Name*:	How often is the amount paid*?	Amount of Court Ordered Child Support Paid*:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

Section 13A : Additional Adult Caretaker Paying Child Support Detail, if applicable

Name*:		Effective Begin Date*:	Effective End Date:
Docket/Court Case #*:	Recipient Name*:	How often is the amount paid*?	Amount of Court Ordered Child Support Paid*:
County Use Only	Verified? Not Available Pending Verbal Written	How Verified?	

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing

Section 14 : Adult Caretaker Receiving Child Support Detail, if applicable				Complete Section 14 for each child listed in Section 3 who receives Child Support payments and/or has an absent parent.	
Child's Name*:		Is Child Support Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do You Receive Child Support? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Docket/Court Case # *:	Name of Absent Parent:		Amount of Court Ordered Child Support received*:		How often is the amount received*?
County Use Only	Verified?	Not Available	Pending	Verbal	Written
					How Verified?

Section 14A : Second Adult Receiving Child Support Detail , if applicable					
Child's Name*:		Is Child Support Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Child Support Received? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Docket/Court Case # *:	Name of Absent Parent:		Amount of Court Ordered Child Support Paid*:		How often is the amount paid*?
County Use Only	Verified?	Not Available	Pending	Verbal	Written
					How Verified?

Note: You may reside in a county that requires Child Support Enforcement participation in order to receive Child Care Assistance Benefits.

- If your county requires this you must cooperate for any child with an absent parent regardless of child care eligibility **unless there is good cause.**
- For more details, please contact your local county Child Care Assistance Program office.

County Use Only					
Non-Custodial Parent Name:			SSN #:		
Non-Custodial Parent DOB:		State ID:			
Visitation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Open Child Support Case? <input type="checkbox"/> Yes <input type="checkbox"/> No		Paying? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Good Cause? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain					

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing

Section 15: Adult Caretaker Job Search Detail, if applicable Complete Section 12 for each Adult Caretaker listed in Sections 2 and 3 who marked "Job Search" in Activity

Name*:	Effective Begin Date*:	Effective End Date:
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What are your Job Search Activities?

County Use Only	Verified? Not Available Pending Verbal Written	How Verified?
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Section 15A: Additional Adult Caretaker Job Search Detail, if applicable

Name*:	Effective Begin Date*:	Effective End Date:
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Job Search Activities

County Use Only	Verified? Not Available Pending Verbal Written	How Verified?
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You **MUST** answer all **YES or NO** questions, sign and date this form.
 Any question answered with N/A will be considered incomplete and may delay application processing

NOTE: Please attach of each school-aged child's SCHOOL CALENDAR/SCHEDULE

Section 16: Child's Care Schedule Complete this section for each Child requesting care ("yes" in Section 5)

Child's Name*: Provider Name*: Provider Address*:				Effective Begin Date*:	Effective End Date:		
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:
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Section 16A: Additional Child's Care Schedule, if applicable

Child's Name*: Provider Name*: Provider Address*:				Effective Begin Date*:	Effective End Date:		
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:
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Section 16B: Additional Child's Care Schedule, if applicable

Child's Name*: Provider Name*: Provider Address*:				Effective Begin Date*:	Effective End Date:		
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:
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Section 16C: Additional Child's Care Schedule, if applicable

Child's Name*: Provider Name*: Provider Address*:				Effective Begin Date*:	Effective End Date:		
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:
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COPY THIS PAGE AS NEEDED FOR ADDITIONAL Child Schedules, if needed

Page _____ of _____

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 obtained directly from me, or from any other person, agency, or institution which provided information to the county department with my written consent.

I understand that:

The county department is authorized to release the following information:

- The Authorization start and end dates;
- Each child's authorized care schedule, including the number of hours per day;
- The amount of the Parent Fee.

And that the county department is authorized to release the information above to the following:

- Any child care provider I may choose to use;
- Any employer for whom I work;
- Any school or training institution I may be attending.

I release the county department from any and all liability for supplying such information.

Signature of Applicant: _____ Date: _____

Signature of Other Adult: _____ Date: _____

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 work;
- Any documentation submitted for self-employment;
- Any school or training institution I may be attending;
- Any other person, agency or institution that may be pertinent, including housing authorities.

Signature of Applicant: _____ Date: _____

Signature of Other Adult: _____ Date: _____

YOU MUST ALSO READ AND SIGN THIS PAGE

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.

Signature of Applicant: _____ Date: _____

Signature of Other Adult: _____ Date: _____

Thank you for completing this form. If you have any questions call the Colorado Child Care Assistance Program (CCCAP) at your county department of social/human services.

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 that 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 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 Parent 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.

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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 20 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 20 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. The person(s) reviewing your case are not responsible for the decision or change you disagree with.

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 county staff who are responsible for making the change in your child care subsidies.

After you have completed a county hearing, if you still disagree with the decision, you may appeal the decision to the State by following these steps:

1. Write a letter to: **Division of Administrative Hearings**
633-17th St, 13th Floor
Denver, CO 80202
2. You must get the letter in the mail not later than 15 days after the county hearing decision has been made.
3. In the letter you need to say 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 you desire to help you, or talk to a legal aid office, or ask your County Social Services people to help you.
4. When your letter is received, you will get a letter from the Office of Appeals explaining what will be done and the date for the appeal hearing. It will also explain who can come with you, who can present testimony and other information about the hearing.

You should be aware that the state and county are required to attempt to collect or get repayment of all benefits provided you for which you were not entitled.

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:

The Secretary of Health and Human Services
370 L'Enfant Promenade, S.W.
Washington, DC 20447

You may have a copy of this page for your reference.

You must submit the following documentation in order to complete your application:

<i>DOES THIS APPLY TO YOU?</i>	<i>What you need to submit</i>	<i>Other Notes</i>	<i>A Checklist for Your Use</i>
YOU OR OTHER ADULTS IN THE HOUSEHOLD ARE WORKING:	All household members' paystubs from the last 3 months and Employer's Name, Address and Phone number.	Records for each job are required, if you (or other household members) have more than one job.	
YOU OR OTHER ADULTS ARE SELF-EMPLOYED:	Self-employment business ledger and copies of your total business earnings and expenditures for the last 3 months	Records for each self-employment activity are required, if you (or other household members) have more than one source of income.	
YOU OR OTHER ADULTS IN THE HOUSEHOLD JUST STARTED YOUR JOB:	Provide a letter from your employer indicating what date you started, what your wages are, how many hours/days you work per week, how often you will be paid and the date of your first paycheck.	Save your paystubs to submit them when you get them.	
YOU LOSE YOUR JOB / OR YOU ARE LOOKING FOR A JOB:	A letter from your employer stating your last date of work and last paycheck date. Proof of job search activities as required by your county child care office.	Job Search Child Care is available on a LIMITED basis and you must have prior approval to use child care services for Job Search.	
YOU PAY CHILD SUPPORT TO SOMEONE OUTSIDE YOUR HOUSEHOLD:	Court documents verifying the amount paid, the frequency of payment(s) and the person(s) receiving the payment(s).	This payment may be deducted from your gross, countable income.	
YOU HAVE NON-WORK OR OTHER INCOME FROM ANY SOURCE:	Proof of source, amount and frequency of payment. Include court documents, if applicable.	See Section 7 of Application for Types of Income that may be included.	
YOU ARE ATTENDING SCHOOL OR TRAINING:	A letter from your school which (1) verifies you are enrolled and are making satisfactory progress. (2) Identifies the program you are enrolled in, and (3) identifies when you are expected to complete the school program. Attach a school schedule which includes (1) start and end dates of quarter, semester, or session; (2) days /time of class and (3) number of credits.	Not all counties provide child care while attending school or training. Check with your county for the policy.	
YOU HAVE CHOSEN A PROVIDER FOR CHILD(REN) REQUESTING CARE:	Name/Address of Provider Verification of child's identification Verification of child's birthdate Verification of child's citizenship Each child's immunization records Verification of Child Support Received (If applicable)	Your county can assist you with selecting a provider and obtaining the documents needed to participate in CCAP. You must have prior approval for payment to be made to the provider. You are responsible for full payment to the provider until that approval is completed.	
YOUR COUNTY HAS VERIFICATION OF YOUR ADDRESS OF RESIDENCE REPORTED ON YOUR APPLICATION (IN SECTION 1)	<i>Proof of address such as:</i> Rent Receipt /Lease copy Mortgage statement Automobile Registration Utility or other bill Verification from Lease Holder/Renter Verification from Other county office Verification from Other Gov't Agency Verification from School Voter Registration	You must verify your address reported on your application; the county can verify that address is within the county.	
YOUR COUNTY CAN CONTACT YOU WITH AT LEAST ONE CONTACT ENTERED	Home Phone Work Phone Mobile Phone E-mail address Emergency Contact		

You may detach and keep this page for your use.