



P: 720-944-KIDS

F: 720-944-3330

1200 FEDERAL BOULEVARD, DENVER, CO 80204

WWW.DENVERCCAP.ORG

Dear Denver CCAP Applicant,

Thank you for your interest in the Child Care Assistance Program (CCAP). We look forward to working with you. Before you review the enclosed application packet, please take a moment to read the following IMPORTANT information:

- **You must apply in your county of residence.** Denver County cannot approve CCAP applications for applicants who live in other counties, so failure to apply in the correct county will result in delays in processing your application.
- **You must be in an eligible activity** (employed, job searching, or attending school/training) to be eligible for CCAP. If you do not list an eligible activity on your application, the application will be denied.
- **If you are currently receiving cash assistance through Colorado Works/TANF, please do not complete this application.** Your Colorado Works case manager can assist you with meeting your child care needs, so please contact your Talent Development Specialist for further assistance.
- **You must comply with Child Support Services** for all children who have a parent outside of the home and for whom you are requesting child care. Once you are approved for CCAP, Child Support Services will be contacting you to schedule an appointment with their office.
- **You can also apply online for CCAP through Colorado PEAK at <https://coloradopeak.secure.force.com/>.** You will still need to provide the documents listed on the checklist included with this application, so please review the checklist and provide those documents to us via one of the methods listed below.

Enclosed is your application packet and a checklist detailing the documents needed for a complete application. Please review the checklist carefully and ensure that you are attaching all necessary documents. If your application is incomplete or missing required documents, it will result in processing delays and/or a denial. If you need help completing your application, please call the KIDS Line (720-944-5437) and leave your name and contact information or email the CCAP team at denverccap@denvergov.org, and a CCAP representative will contact you.

To return this information to us, you may:

- Scan and email application and documents to denverccap@denvergov.org.
- Drop the documents in a CCAP Drop Box at:
 - Denver Human Services Castro Office located at 1200 Federal Blvd. Drop Boxes are located near the 1st floor security desk, in the Self-Service Center (Room 1026) on the 1st floor, and on the 2nd floor near the top of the stairs.
 - Montbello DHS Office located at 4685 Peoria St. Drop box is located in the lobby.
 - East DHS Office located at 3815 Steele St. Drop box is located in the lobby.
- Mail your application to Denver Human Services at 1200 Federal Blvd., Denver, Colorado 80204. Attention: CCAP.
- Fax the documents to 720-944-3330. Attention: CCAP.

Sincerely,

Your Denver County CCAP Team

CHECK LIST FOR NEW DENVER CCAP APPLICATIONS

COMPLETE ENCLOSED FORMS

- CCAP Application:** Please complete all sections. If a section does not apply to you, mark it "N/A"
- Authorization to Supply/Release Information**
- Client Responsibility Agreement**
- Non-school Days Care Request** (for school-age children)
- Voter Registration** (Optional)

INCLUDE COPIES OF THE FOLLOWING DOCUMENTS

- Birth certificates and Parent(s) Photo ID:** for all children in the household for whom you are requesting care.
- Verification of County Residency:** current utility bill or lease/mortgage statement. If you live with someone else and do not receive bills in your name, a Verification of Residency form is attached for your convenience. If you do not live in Denver County, you **MUST** submit your application in the county in which you reside.
- Income Verification:** verification of all household income for the last 30 days: this includes pay stubs, self-employment ledgers, child support, SSI, unemployment, bonuses, money received from other people, in-kind income such as meals or rent in exchange for work, etc.
- Verification of Custody Schedule:** for children needing care who are part of a joint custody arrangement.
- Provider Choice:** select a child care provider(s) and list in Section 13 of the application. Please ensure that you have contacted the potential child care provider and that they have a vacancy for your child. You can dial 2-1-1 or visit www.coloradoshines.com for help locating quality child care providers in your area.

INCLUDE DOCUMENTATION OF YOUR ELIGIBLE ACTIVITY

- Employment:** If your eligible activity is employment, please include the following information:
 - Verification of Employment:** 30 days of paystubs. If you have been at your job for less than 60 days and do not have 30 days of paystubs, please have your employer complete the attached Verification of Employment form or write a letter on company letterhead including the information requested on the form.
 - Work Schedule:** a schedule is only needed if you are requesting child care outside of traditional hours (Monday-Friday, 6am-6:30pm) as declared on Section 13 of the application. This can be two weeks of posted work schedules, or letter from employer verifying schedule. Verification of Employment form is attached for your convenience.
- Self-employment:** If your eligible activity is self-employment, please include the following information:
 - One Month of Ledgers:** including income and expenses with invoices and receipts.
 - Declared Work Schedule:** your schedule for the hours that you are in your self-employment activity.
- Education/Training:** If your eligible activity is education/training, please include the following information:
 - Verification of Current School Enrollment:** Letter from the school verifying your enrollment.
 - School Schedule:** a schedule is only needed if you are requesting child care outside of traditional hours (Monday-Friday, 6am-6:30pm) as declared on Section 13 of the application. The schedule should include dates and times of classes.
- Job Search:** If your eligible activity is job search, please include the following information:
 - Job Search Agreement:** please complete the attached Job Search Agreement.

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*? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there other Adult Caretaker(s) in the household*? <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? Please complete if applicable.	<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: *Complete at least one	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:		
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		<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

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

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
ACTIVITY*: Check all that apply to this individual				
<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				
**An additional adult caretaker in the household is one who provides financial assistance and helps care for your child				
*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
ACTIVITY*: Check all that apply to this individual				
<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)	

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

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

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*:	
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"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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?*	
Is this child part of a foster custody arrangement?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Immunization status: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Religious Exemption <input type="checkbox"/> 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?*	
If yes, what is their enrollment start date and end date? Start: ___/___/___ End: ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No	
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:
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*:	
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"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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?*	
Is this child part of a foster custody arrangement?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Immunization status: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Religious Exemption <input type="checkbox"/> 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?*	
If yes, what is their enrollment start date and end date? Start: ___/___/___ End: ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No	
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

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

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

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*:	
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"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Religious Exemption <input type="checkbox"/> 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:
Social Security Number (Optional):	Date of Birth*:	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker*:	
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"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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: <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Religious Exemption <input type="checkbox"/> 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

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN

Page _____ of _____

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

Section 5: Primary Caretaker Work/Self-Employment Income							
Do you have Work or Self-Employment income?* <input type="checkbox"/> Yes <input type="checkbox"/> 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?* <input type="checkbox"/> Yes <input type="checkbox"/> 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)?* <input type="checkbox"/> Yes <input type="checkbox"/> 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?* <input type="checkbox"/> Yes <input type="checkbox"/> 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			

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

Section 9: Other Income* Complete information in Section 9 for each person in your household.

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?
Other Income Types: 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 <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 AmeriCorps Income Worker's Compensation Old Age Pension	<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
Assets: 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: \$ _____
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?
Other Income Types: 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 <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 AmeriCorps Income Worker's Compensation Old Age Pension	<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
Assets: 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 _____

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

Section 10: Adult Caretaker Training/Education/Teen Education Detail

Are you or another household member participating in a training/education activity?* Yes 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*:

Section 11: Adult Caretaker Disability Detail

Are you or another Adult Caretaker disabled?* Yes 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

Section 12: Adult Caretaker(s) Employment/Training/School/Job Search Schedule*
 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.)

Example	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
MY SCHEDULE							
Work/Job Search							
Training/School							
2ND ADULT CARETAKER							
Work/Job Search							
Training/School							

Section 13: Children's Schedule for children needing care* (Do not complete for children who do not need care.)

Child's Schedule. Please indicate times you plan to have your child in care each day for each provider used

Child Name	Child In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Grade and School Of Attendance	Provider License #, Name, Address and Phone # (if known)	Child's Schedule								
				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		

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

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

Denver Department of Human Services Information Concerning a Good Cause Exemption of Cooperation in Pursuing Child Support

Cooperating with Child Support Services is a requirement for receiving Child Care Assistance.

As a part of the eligibility criteria for the Denver Child Care Assistance Program, recipients must cooperate with Child Support Services (CSS) for establishment, modification, and enforcement services related to any support owed by a non-resident parent to his or her child(ren) unless claiming good cause for noncooperation.

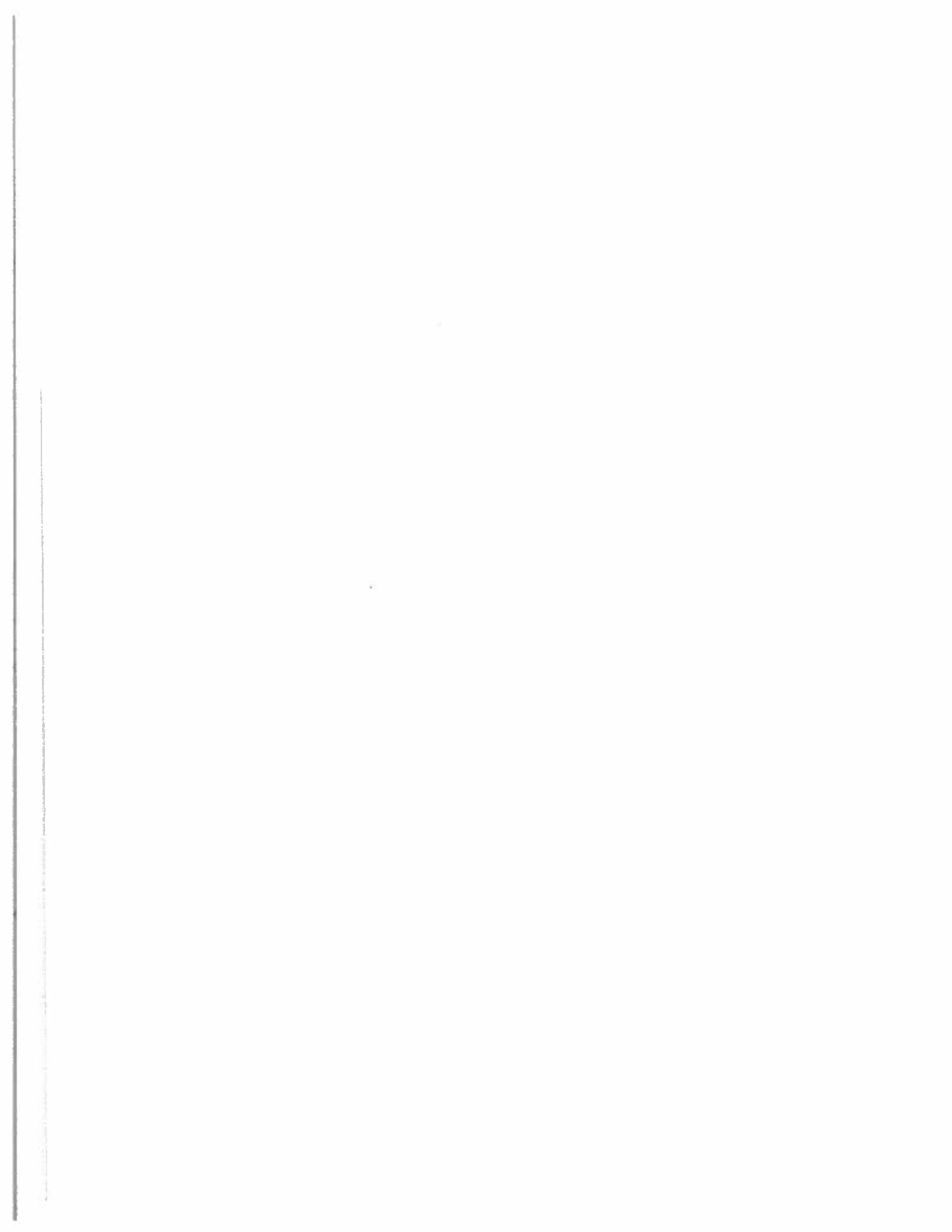
“Good Cause” includes, but is not limited to, the following criteria:

- There is potential for physical or emotional harm to a child or children; or
- There is potential for physical or emotional harm to a parent or caretaker relative; or
- Pregnancy or birth of a child related to incest or rape; or
- The child was legally adopted in a court of law or a parent receiving pre-adoption services.

Documentation to support your request is not required, but can provide clarity and information to aid in the decision about your request. Suggested documents may include:

- Police report
- Medical report
- Restraining order
- Statement from a physician, mental health worker or social case worker

You may request a review of your case for good cause for not cooperating with Child Support Services by contacting the CCAP team. The County will review and make a determination regarding good cause within fifteen (15) calendar days from receipt of the request.





P: 720-944-KIDS

F: 720-944-3330

1200 FEDERAL BOULEVARD, DENVER, CO 80204

WWW.DENVERCCAP.ORG

CCAP Non-School Days Request Form

Please complete this form for any school-aged children in your household who normally receive part time care (before/after school) but will require full-time care on days when they are not in school. Completing this form allows the Denver CCAP team to ensure that your child care provider is paid correctly.

Child Name: _____

School District: _____

Child Name: _____

School District: _____

Child Name: _____

School District: _____

Child Name: _____

School District: _____

Child Name: _____

School District: _____

For any school/district that does not follow the same schedule as Denver Public Schools, please attach a copy of the school's calendar that indicates the days when school is not in session.

By signing below, I indicate that I am requesting full-time care for the children listed above on days when they are not in school, as indicated by the calendar provided. I understand that I am responsible for providing a school calendar showing the days that school is not in session and for notifying Denver CCAP of any changes to the school calendar, so that Denver CCAP can correctly authorize my children for care. If my children attend care full time on days when they are not authorized to do so, I will be responsible for payment to the child care provider.

Client name (printed): _____ Case number: _____

Signature: _____ Date: _____





P: 720-944-KIDS

F: 720-944-3330

1200 FEDERAL BOULEVARD, DENVER, CO 80204

WWW.DENVERCCAP.ORG

Verification of Residency

CCAP requires that clients verify their residency in the county in which they are applying for assistance by supplying a current lease, utility bill, or mortgage statement with their name and address. If you live with someone else and do not receive any of these forms of verification in your own name, please have the person with whom you live complete the below form.

I, _____ (name of person with whom you are staying) verify that
_____ (name of applicant) resides with me at
_____ (address).

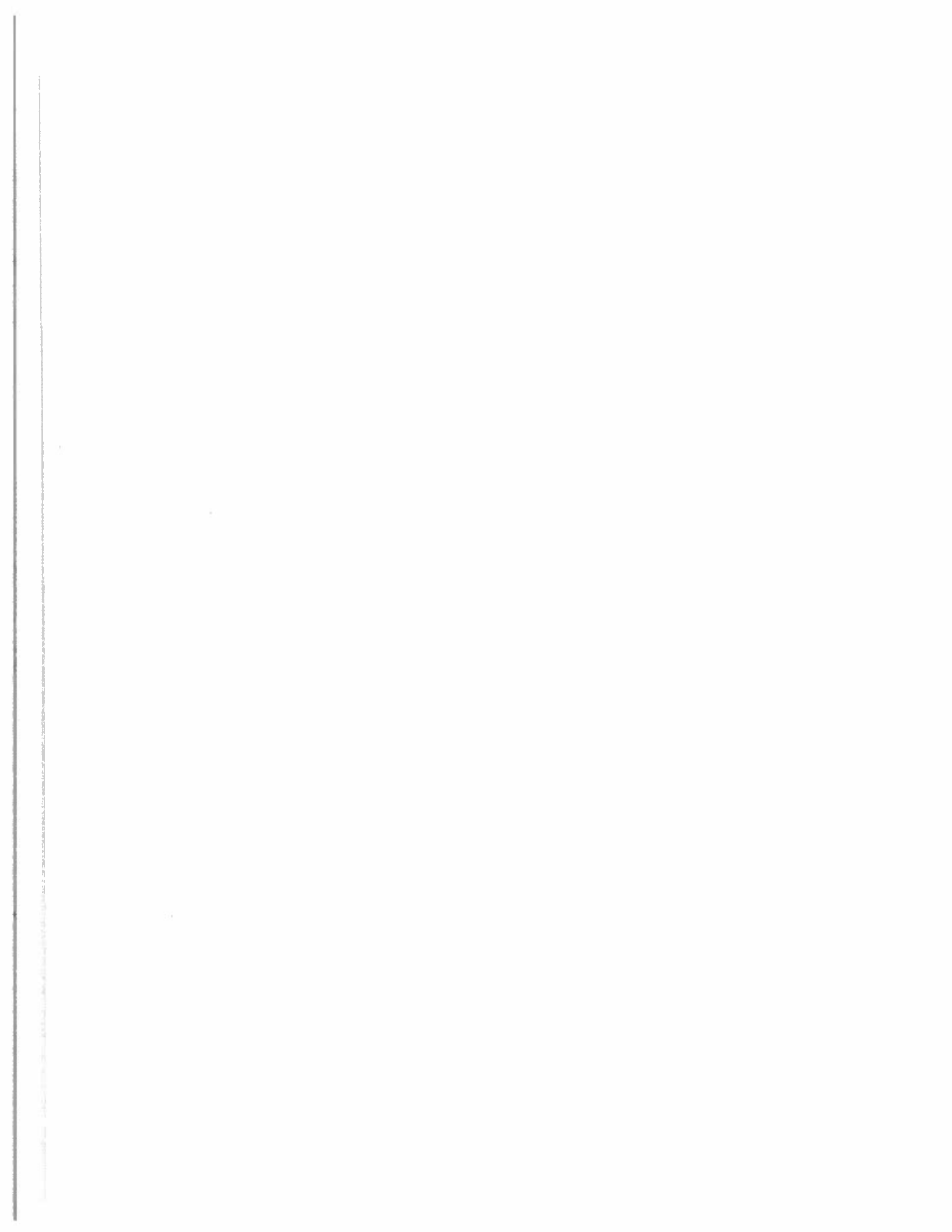
Signature: _____

Phone number: _____

Please attach a current lease, mortgage statement, or utility bill with the name and address of person whose signature is above.

Thank you,

Denver CCAP Team





P: 720-944-KIDS

F: 720-944-3330

1200 FEDERAL BOULEVARD, DENVER, CO 80204

WWW.DENVERCCAP.ORG

Verification of Employment

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

Client Section

Name: _____ Social Security Number: ____ - ____ - ____

CCAP Worker: _____ Date: _____

Employer Section: **TO BE COMPLETED BY EMPLOYER**

The above person has indicated that s/he is employed with your business. Please complete the following information and return to the employee or directly to Denver Human Services via mail, fax, or email (denverccap@denvergov.org).

Name of Business: _____

Business Address: _____

First Day of Employment: _____ First Check Date: _____

Weekly Work Schedule

Sun	Mon	Tues	Wed	Thur	Fri	Sat	Total Hrs per week
Example	8:00a- 5:00pm	8:00am 5:00pm	8:00am 5:00pm	8:00am 5:00pm	Off	Off	32

Please fill in above weekly schedule – if flex schedule, please mark any regular days off (OFF) - Fill in other days as best you can.

Rate of Pay: _____ Monthly Gross Wages: _____

How often paid: _____ Taxes Withheld: Yes/No

Additional Income: (Overtime/Commission/Bonuses/Tips): Yes/No Explain: _____

If so, how often: _____ How Much: _____

I confirm that the above information is complete and accurate.

Print Name

Title

Phone number

Signature

Date



1200 FEDERAL BOULEVARD, DENVER, CO 80204

P: 720-944-KIDS

W: WWW.DENVERCCAP.ORG

Job Search Client Responsibility Agreement

I, _____ agree to the following conditions while receiving assistance with my childcare cost for Job Search Activities.

1. I understand that I may receive a maximum of **13 consecutive weeks** of subsidized childcare for the job searching in a 12-month period. The 12-month period of time begins with the first day of the first week of job search activity.
2. I understand that in order to begin job search activities, I must have a **child care provider who has agreed to accept my child**. If my child is on a waiting list at a provider, I understand that I must inform my caseworker of this; otherwise, weeks for which I am authorized for job search but am not able to take my child to care because he or she is on a waiting list will count against my 13 weeks of job search.
3. If I have scheduled care with a childcare provider and my child is absent that day, I understand that the absence counts toward my **13 week maximum** for the year.
4. I agree to notify my caseworker within **(5) five days** of becoming employed and will supply written employment verification within **10 days**. I understand that my job search time will continue to count until CCAP receives written verification of my new employment from my employer, including my start date, rate of pay, first paycheck date, and work schedule.
5. I understand that if I do not submit a written letter of employment before the end of my Job Search period, my case will be set to close and any care I use after that date will be at my own expense.

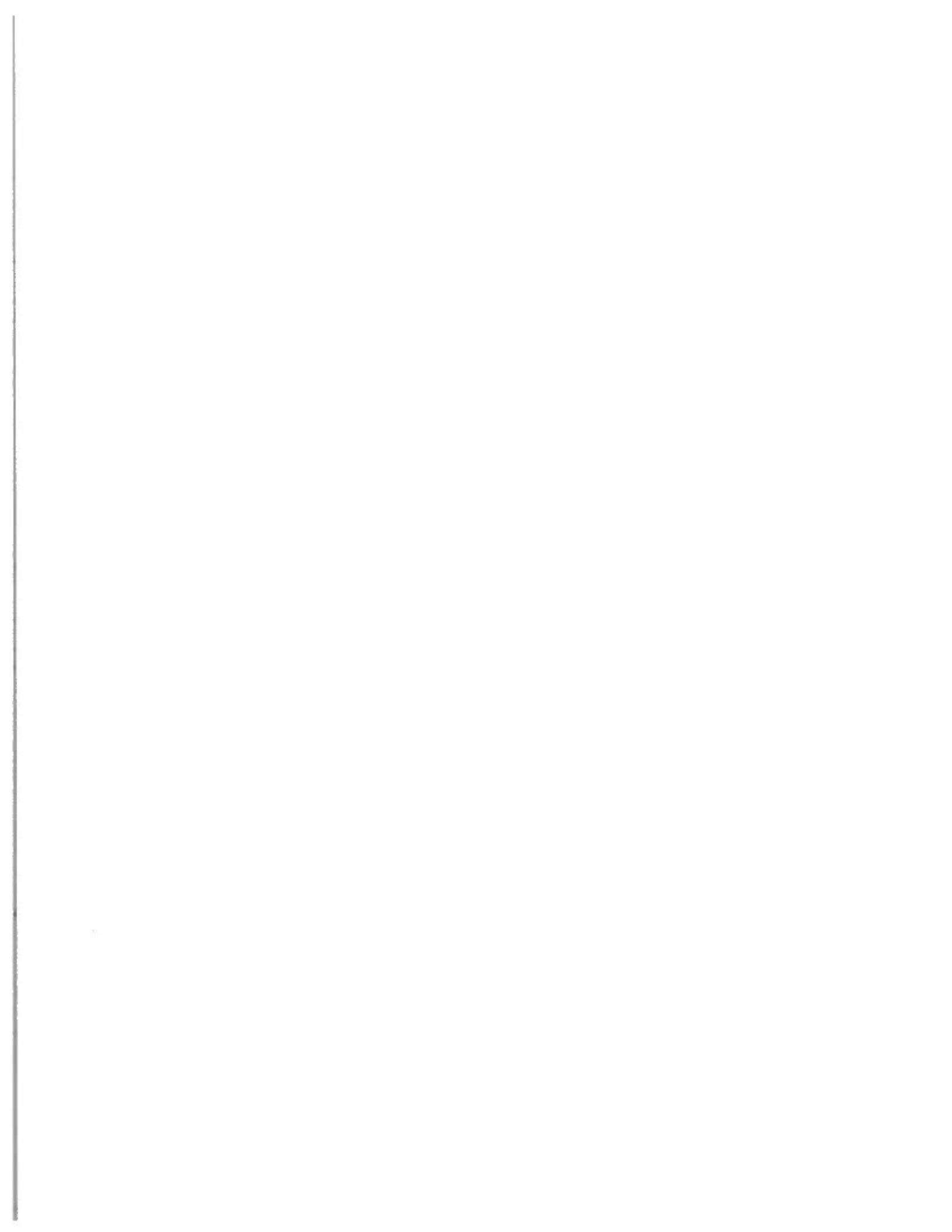
Client Signature: _____

Date: _____

Caseworker Signature: _____

Date: _____

HH #: _____



Voter Registration Choice Form

Instructions

Please read the following information and complete and sign the form below. This agency will keep the form for its records.

Important Notice

You may file a complaint with the Colorado Secretary of State if you believe that someone has interfered with your right to:

- register or decline to register to vote,
- privacy in deciding whether to register or in applying to register to vote, or
- choose your own political party or other political preference.

Send complaints to:

Colorado Secretary of State
1700 Broadway
Denver, CO 80290
Phone: (303) 894-2200

You may apply to register to vote or update your current registration today

- If you are not registered to vote where you live now, you may apply to register to vote here today.
- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

Does filling out or not filling out the registration form affect services I am applying for?

No. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

How private is this process?

The name and location of the agency or public office where you received the voter registration application will not appear on your records. If you decide not to use this application to register to vote, that is also confidential.

Complete and sign below

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Please check only one of the following boxes. If you do not check either box, you will be considered to have decided not to register to vote at this time.

Yes, I want to apply to register to vote today. (Please fill out the Voter Registration Form)

You are eligible to register to vote if you:

- Are a United States citizen.
- Are a resident of the state of Colorado for at least 22 days before the election at which you intend to vote,
- Are at least 16 years of age but you must be 18 years of age or older on the date of the election at which you intend to vote,
- Are NOT serving a sentence (including parole) for a felony conviction.

No, I do not want to apply to register to vote today.

Your full name (please print)

Signature

Today's date (MM/DD/YY)

For office use only

Date: _____

The applicant completed a voter registration form

Yes No

The applicant requested and was given a voter registration form for later delivery

Yes No

Employee Initials: _____



Colorado Voter Registration Form

For office use only
Voter ID Number: _____

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

Your eligibility to vote

Are you a citizen of the United States? Yes No If you answered "No", do not complete this form.

Helping with elections

I would like to be an election judge. Yes No

Your name

Last name* First name* Middle name Suffix
Previous name if you are currently registered to vote with a different 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 and the last 4 digits are X X X - X X -
- 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

Address where you would like your ballot mailed (if different from your home or mailing address)

Address Apt. or Unit City or Town State ZIP Code

Your former home 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

Area code Phone number

Election information by email

Would you like to receive election information by email? Email address
(You will not receive a ballot by email.) Yes No

Select or change your political party affiliation

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

American Constitution Democratic Green Libertarian Republican Unity Unaffiliated

Sign or mark below

Warning: A violation of the self-affirmation you are about to make is a criminal act under the laws of this state and will subject you to the penalties provided by law. It is a Class 1 misdemeanor to swear or affirm falsely as to your qualifications to vote. I am aware that if I register to vote in Colorado I am also considered a resident of Colorado for motor vehicle registration and operation purposes and for income tax purposes.

Self-Affirmation: I affirm that I am a citizen of the United States; I have been a resident of the state of Colorado for at least twenty-two days immediately prior to an election in which I intend to vote; and I am at least sixteen years old and understand that I must be eighteen years old to be eligible to vote. I further affirm that my present address as stated herein is my sole legal place of residence, that I claim no other place as my legal residence, and that I understand that I am committing a felony if I knowingly give false information regarding my place of present residence. I certify under penalty of perjury that I meet the registration qualifications; that the information I have provided on this application is true to the best of my knowledge and belief; and that I have not, nor will I, cast more than one ballot in any election.

Sign here

Signature or Mark* Date* Witness Signature Date

(If you are unable to sign, you must make a mark and a witness to the mark must sign here.)

