



Dear Denver Child Care Assistance Program 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 them for 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 www.colorado.gov/peak.** 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 using 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 of child care benefits. If you need help completing your application, please call the Denver CCAP 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 Richard T. Castro Human Services Center located at 1200 Federal Blvd. Drop Boxes are located near the 1st floor security desk, in the Self-Service Center (Room 1026) on the first floor, and on the second floor near the top of the stairs.
 - Arie P. Taylor Building 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
Attention CCAP
1200 Federal Blvd.
Denver, CO 80204
- Fax the documents to 720-944-3330. Attention: CCAP.

Sincerely,

Your Denver County CCAP Team

CHECK LIST FOR NEW DENVER CHILD CARE ASSISTANCE PROGRAM APPLICATIONS

COMPLETE ENCLOSED FORMS

- CCAP Application: Please complete all sections and sign the application.
- Email Address: CCAP requires an email address to use our attendance tracking system. **You MUST supply an email address, or your case will not be approved.**
- Authorization to Supply/Release Information
- 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 call the Mile High United Way Childcare Referral line at 211 or visit www.coloradoshines.com for help locating quality child care providers in your area.
- Non-school Days Care Request for school-age children needing full time care on school closure days (optional)
- Voter Registration (optional)

INCLUDE COPIES OF THE FOLLOWING DOCUMENTS

- Citizenship Documentation and Parent(s) Photo ID:** birth certificates or other citizenship documentation for all children in the household for whom you are requesting care.
- Verification of County Residency:** utility bill or lease/mortgage statement showing name and address and received within the last 60 days. 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.

INCLUDE DOCUMENTATION OF YOUR ELIGIBLE ACTIVITY

- Employment:** If you are employed, 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 or you do not receive 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, 6 a.m. - 6:30 p.m.) as declared on Section 13 of the application. This can be two weeks of posted work schedules, or letter from employer verifying schedule.
- Self-employment:** If you are self-employed, please include the following information:
 - One Month of Ledgers: including income and expenses with invoices and receipts. If you need a form to report this information, please request one from your caseworker.
 - Declared Work Schedule: your schedule for the hours that you are in your self-employment activity.
- Education/Training:** If you are attending school or 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, 6 a.m. - 6:30 p.m.) as declared on Section 13 of the application. The schedule should include dates and times of classes.
- Job Search:** If you are seeking child care to search for a job, indicate this in Section 2 and/or 3 of the application.

Application Received Date:	Pre-Eligibility: Yes <input type="checkbox"/> No <input type="checkbox"/> Determined by: Provider <input type="checkbox"/> County <input type="checkbox"/>	Case Number:
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Application for Colorado Child Care Assistance Program. (CCCAP)

- **Completion of this application does not guarantee you will receive child care assistance.**
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please provide all requested information
- Missing information will delay your application.
- **Teen Parents:** Do not include information about your parents even if you live with them.

Section 1: Household Information					
Today's Date: ____/____/____		If you are not the parent of child(ren) for whom you are applying, are you the Primary Adult Caretaker? Are there other Adult Caretaker(s) in the household?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Adult Caretaker's Last Name:		Primary Adult Caretaker's First Name:		Middle Initial:	
Do any of the following apply to your current living situation? 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"/> Other irregular living situation (please explain)		Date living situation began: ____/____/____ Anticipated end date: ____/____/____		
Residence Address:			Mailing Address: <input type="checkbox"/> Same as residence?		
City:	State:	Zip:	City:	State:	Zip:
County:			Primary language spoken in the home:		
Contact Information: <i>Complete at least one</i>	Primary Phone: () Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	Secondary Phone: () Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	Email Address:		
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

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
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 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"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Immunization status: <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	
If yes, what is their enrollment start date and end date? Start: ____/____/_____ End: ____/____/_____	
Does this child have a disability or have additional care needs?	<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"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Immunization status: <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	
If yes, what is their enrollment start date and end date? Start: ____/____/_____ End: ____/____/_____	
Does this child have a disability or have additional care needs?	<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:
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Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to the Primary Adult Caretaker:
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Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White <input type="checkbox"/> Other

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Immunization status: Yes, Immunized No, In Process No, Religious Exemption No, Medical Exemption

Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does this child have a disability or have additional care needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start:____/____/____ End:____/____/____				

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Section 4 Cont'd Complete this section for each child in your home

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

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child part of a foster custody arrangement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Immunization status: Yes, Immunized No, In Process No, Religious Exemption No, Medical Exemption

Is this child enrolled in a Head Start/Early Head Start Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does this child have a disability or have additional care needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what is their enrollment start date and end date? Start:____/____/____ End:____/____/____				

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN

Page _____ of _____

Section 5: Primary Caretaker Work/Self-Employment Income

Do you have Work or Self-Employment income? Yes No

If YES complete the following: Please list all employment. (VERIFICATION IS REQUIRED.)

Name of caretaker	Employer or Business Name and Telephone Number	Work/Self-Employment Start Date	Self-Employed	LLC or S-Corp?	# of hours per week	How often paid	Total earnings per pay period (including tips & commissions)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$

Section 6: Additional Adult Caretaker/Spouse Work/Self-Employment Income

Do you have Work or Self-Employment income? Yes No

If YES complete the following: Please list all employment. (VERIFICATION IS REQUIRED.)

Name of caretaker	Employer or Business Name and Telephone Number	Work/Self-Employment Start Date	Self-Employed	LLC or S-Corp?	# of hours per week	How Often paid	Total earnings per pay period (including tips & commissions)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$

Section 7: Court Ordered Child Support Paid Out

Do you make child support payments for any child(ren)? Yes No

If YES complete the following: (VERIFICATION OF COURT ORDER AND PAYMENT IS REQUIRED.)

Name of person making payment	Child(ren) out to	Amount paid	How often paid
		\$	
		\$	

Section 8: Child Support Ordered and/or Received

Has child support been ordered and/or has it been received? Yes No

Child Name(s)	Is child support ordered?	Is child support received?	Amount of Child Support Paid	How often paid	Name of non-custodial parent
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

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 <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 <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 <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 <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 _____

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:	

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 Name	Child In School	Grade and School Of Attendance	Child's Schedule: Please indicate times you plan to have your child in care each day for each provider used							
			Provider License #, Name, Address and Phone # (if known)	Mon. 8:00a - 5:00p	Tues. 8:00a - 5:00p	Wed. 8:00a - 5:00p	Thurs. 8:00a - 5:00p	Fri. 8:00a - 5:00p	Sat. 8:00a - 5:00p	Sun. 8:00a - 5:00p
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									



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: _____

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 (found on www.coloradoofficeofearlychildhood.com) 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.
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 use the State Attendance System as designed to check my child(ren) in and out of the child care facility.
11. 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.
12. 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 at re-determination and will not be able to receive assistance with another child care provider and/or through any other county.

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

Colorado Voter Registration Form

Fill out all fields marked with an asterisk (*)

Eligibility **1** * Are you a citizen of the United States? Yes No **If you answered "No", do not complete this form.**

Name **2** _____
 * Last Name * First Name Middle Name Suffix

Identification **3**  Remember to write your birth date below.
 Provide your birth date and check one of the boxes.
 I have a valid CO Driver's License or ID card and that number is: _____ - _____ - _____
 I do not have a CO Driver's License or ID card, but the last 4 digits of my Social Security Number are: X X X - X X - _____
 * Birth date (MM / DD / YYYY) I do not have a Colorado Driver's License, ID card, or a Social Security Number.

The address where you live **4** I am homeless. This is a location I regularly return to. I have also provided a mailing address in Section 5.
 * Address (no P.O. Boxes) _____ Unit Number _____ * City or Town _____
 CO _____
 State * Zip Code _____ Colorado County _____ *When did you move to this address? _____

The address where you receive mail **5** Same as above _____
 Address _____
 City or Town _____ State _____ Zip Code _____


The address to mail your ballot **6** Same as above _____
 Address _____
 City or Town _____ State _____ Zip Code _____
 The County will mail your ballot here until you say otherwise.

Political party **7** American Constitution Green Republican No party preference (unaffiliated)
 Select one. Democratic Libertarian Unity

Unaffiliated? **7a** Unaffiliated voters can choose which ballot to receive in the next primary election or select "Receive all participating party ballots".
 Choose which ballot you want in the next primary. Receive all participating party ballots (see reverse for details) American Constitution Green Republican
 Democratic Libertarian Unity

Updating a current record? **8** _____
 Previous home address Previous legal name

 Previous mailing address Previous party affiliation
 I am no longer overseas I am no longer absent from Colorado due to military service

Declaration **9**  **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.

 * Signature or mark * Date Witness Signature Date
 If you are unable to sign, you must make a mark and have the mark witnessed by another person.

Optional information **10** _____
 Phone number with area code Gender Identity I would like to be an election judge
 I want to receive election information by email: _____
 (You will not receive a ballot by email) Email address _____

Information about this registration

How do I turn in this form?

Sign the form. Then mail, deliver, or scan the signed form and email it to your county clerk and recorder. You may find a list with contact information at www.govotecolorado.com.

You may also mail it to:

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

Am I eligible to register to vote?

You are eligible to register to vote if you:

- Are a United States citizen
- Are 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 a Colorado resident for at least 22 days immediately before the election at which you intend to vote
- Are not serving a sentence (including parole) for a felony conviction

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

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

If I don't have a Colorado driver's license, Colorado ID card, or social security number, may I still register to vote?

Yes. An applicant who is qualified to vote in this state but does not have a driver's license, state-issued identification card, or social security number may still register to vote. In such cases, the person may be required to provide an acceptable form of identification. A list of acceptable forms of identification can be found at <http://www.govotecolorado.com>.

How will I know if my registration was processed?

If you are registering to vote for the first time in the state of Colorado, your application will be processed within 2 weeks. Approximately 20 days after your county clerk and recorder receives your registration form, you will receive an official information card by mail.

If you are using this form to update an existing Colorado voter registration, you can check your status by visiting www.govotecolorado.com and clicking on "Find My Registration".

Information for unaffiliated voters

I am registered as unaffiliated. Will I be able to vote in the primary election?

Yes. Unaffiliated voters are eligible to vote in any party's primary election, but you may only vote one party's ballot.

Do I have to choose in advance which party's ballot I want to vote?

No, but you can if you want to. You have several options:

1. You may choose which party's ballot you want to get in the mail for the next primary election by checking the box next to that party in Section 7a of this form; or
2. If you would rather receive a packet containing the ballots of all participating parties, check "Receive all participating party ballots" in Section 7a of this form.
3. You can also appear in person at any Voter Service and Polling Center in your county and choose the party's ballot you want to vote.

Does selecting a preference in Section 7a mean that I am joining that party?

No. An unaffiliated voter who selects a ballot preference in Section 7a will remain unaffiliated.

Can I participate in a party's caucus meeting if I am unaffiliated?

No. To participate in a party caucus meeting you must join that party before the party's caucus. However, you are still eligible to vote in any participating party's primary election.

Other frequently asked questions about registering and voting

Will I need identification to vote?

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

A complete list of acceptable forms of identification can be found at <http://www.govotecolorado.com>.

How do I get a mail ballot?

If you register to vote at least eight days before an election conducted by your county clerk and recorder, the clerk will automatically mail you a ballot. If you register after the eighth day before Election Day, you must visit one of the Voter Service and Polling Centers in your county to get a ballot.

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

Yes, if you

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

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

What information will I receive by email?

By choosing to receive election information by email, you will receive information about upcoming election activities by email. But ballots and some mailings will still be sent by regular mail. Under Colorado law, your email address is protected. It will not be shared with anyone.

Will my information be publicly available?

Some of the information you provide on this form is public information as required by law. Your social security number, driver's license number, month and day of birth, signature, and email are confidential. You may be eligible to keep more of your voter information private. For details contact your clerk and recorder.

Who should I contact if I have more questions?

Contact your county clerk and recorder. You can find a list with contact information at www.govotecolorado.com.

You may also contact the Secretary of State's office

Phone: 303-894-2200

Fax: 303-869-4861

Email: State.ElectionDivision@sos.state.co.us

CHILD CARE ASSISTANCE PROGRAM 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 Name/District: _____

Child Name: _____

School Name/District: _____

Child Name: _____

School Name/District: _____

Child Name: _____

School Name/District: _____

Child Name: _____

School Name/District: _____

Child Name: _____

School Name/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.

Participant name (printed): _____ Case number: _____

Signature: _____ Date: _____



CHILD CARE ASSISTANCE PROGRAM VERIFICATION OF EMPLOYMENT

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

Participant Section

Name: _____ Date: _____ CCAP Case #: _____

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 participant or directly to Denver Human Services by mail, fax, or email.

Business Information

Name of Business: _____

Business Address: _____

Hiring Information

First Day of Employment: _____ First Check Date: _____

Wages

Number of Hours Worked per Week: _____ Rate of Pay: _____

How often paid: _____ Monthly Gross Wages: _____

Taxes Withheld: Yes No

Additional Income (overtime/commission/bonuses/tips): Yes No

If so, how often: _____ How Much: _____

Schedule

Nontraditional hours are weekday nights and evenings between 6 p.m. and 6:30 a.m. and any time on weekends.

Is this employee scheduled to work nontraditional hours: Yes No

If yes, please include a copy of employee's work schedule with this form.

Information of Person Completing this Form:

Print Name

Title

Phone number or Email Address

Signature

Date



CHILD CARE ASSISTANCE PROGRAM VERIFICATION OF RESIDENCY

The Child Care Assistance Program requires that participants verify that they live in the county in which they are applying for assistance by providing 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 pieces of mail in your own name, please have the person with whom you live complete the below form.

I, _____ (name of person with whom participant is staying) verify that
_____ (name of participant) 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.

CHILD SUPPORT SERVICES GOOD CAUSE EXEMPTION POLICY

If you are a parent or caretaker who is owed child support by a non-custodial parent to your child(ren), you are required to work with the Denver Human Services Child Support Services (CSS) team for establishment, modification, and enforcement of child support payments in order to receive child care assistance, unless you are claiming “Good Cause” for noncooperation.

Reasons for “Good Cause” include, but are not limited to, the following:

- 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 your Denver Child Care Assistance Program technician. The Denver CCAP team will review and make a determination regarding good cause within fifteen (15) calendar days from receiving your request.