Denver County
CCAP
CHILD CARE ASSISTANCE PROGRAM
P: 720-944-KIDS F: 720-944-3330 1200 FEDERAL BOULEVARD, DENVER, CO 80204 WWW.DENVERCCAP.ORG

Dear CCAP Applicant,

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

- You must meet with Child Support Services.
- You must apply in your county of residence.
- You must be involved in an eligible activity (employed, job searching, or attending school).

Enclosed is your application packet. Please carefully complete the entire packet and attach required documentation before submitting your application. If your application is incomplete or missing required documents it may 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.

You may:

- Scan and email application and documents to denverccap@denvergov.org.
- Write "Attention CCAP" at the top of your documents and drop the documents in a CCAP Drop Box at:
  - Denver Human Services Office located at 1200 Federal Blvd. Drop Boxes are located on the 1st floor near the 1st floor security desk, in the Self-Service Center 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 CCAP APPLICATIONS

Complete enclosed forms:

- € CCAP APPLICATION
- € Client Responsibility Agreement
- € Non-school Days Request
- € Verification of Employment
- € Voter Registration (Optional)

COPIES OF THE FOLLOWING DOCUMENTS:

- € Birth certificates for all children in household for whom you are requesting care and Parent(s) Photo ID(s). Original documents MUST be verified (attested to) by a CCAP worker or in the Self-Service Center at 1200 Federal Blvd (Room 1026).

- € Verification of Residency: Current utility bill or lease/mortgage statement. If you have no bills in your name and live with someone else, please have that person fill out the attached Verification of Residency Form and include a current bill/lease/mortgage statement in his or her name.

- € Job Search Agreement: If your eligible activity is job search, please select a child care provider and complete the attached Job Search Agreement.

- € School Verification: If your eligible activity is attending school, provide a current school schedule, including dates and times for classes.

- € Income Verification: Please send in last 30 days of complete paystubs. If employed less than 30 days, send letter of employment signed by your employer. Verification of employment letter is enclosed for your convenience.

- € Work Schedule: Verification of your work schedule. (This can be your posted schedule or a statement from your employer.) If you have a variable schedule, please have your employer verify all possible work days and possible work hours.

- € Provider Choice: Please select a child care provider and list on application along with their provider number, name and phone number. Please ensure that you have contacted the potential child care provider and that they have a vacancy. If you do not have a preferred child care provider, feel free to contact #211 or visit www.qualistar.org or www.coloradoshines.com.

Application Received Date:	Pre-Eligibility: Yes ☐ No ☐ Determined by: Provider ☐ County ☐	Case Number:

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*?	☐ Yes ☐ No ☐ Yes ☐ 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.**	☐ Living in hotel or motel	☐Living in campground	☐ Living in shelter	☐ Living in substandard housing such as car, park, etc.
	☐ Living situation (please explain)		Date living situation began: ____/____/_____ Anticipated end date: ____/____/_____	

Residence Address*:			Mailing Address*: ☐ 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:☐ Home ☐Cell ☐ Voice Msg.☐ Work	Secondary Phone*: ( ) Type:☐ Home ☐Cell ☐ Voice Msg.☐ 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	☐ Yes ☐ No	☐ Yes ☐ No
Head Start/Early Head Start	☐ Yes ☐ No	☐ Yes ☐ No
Low-Income Energy Assistance (LEAP)	☐ Yes ☐ No	☐ Yes ☐ No
Food Assistance (SNAP)	☐ Yes ☐ No	☐ Yes ☐ No
Women, Infants and Children (WIC) Program	☐ Yes ☐ No	☐ Yes ☐ No
Child and Adult Care Food Program	☐ Yes ☐ No	☐ Yes ☐ No
Medicaid/CHP+ Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Housing voucher or cash assistance	☐ Yes ☐ No	☐ Yes ☐ No
Refugee Medical Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Individuals with Disabilities Education (IDEA) Services Part B (3-5yrs)	☐ Yes ☐ No	☐ Yes ☐ No
Individuals with Disabilities Education (IDEA) Services Part C (0-3yrs)	☐ Yes ☐ No	☐ Yes ☐ No
Old Age Pension	☐ Yes ☐ No	☐ Yes ☐ No
Other (please explain):_____	☐ Yes ☐ No	☐ Yes ☐ No

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*: ☐ Male ☐Female

Race (optional, mark all that apply):	☐ American Indian or Alaskan Native	☐ Native Hawaiian or Pacific Islander	Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic
	☐ Asian ☐ Black	☐ White ☐ Other	

Highest Grade Completed*:	☐ Less Than High School/High School Equivalency	☐ High School/High School Equivalency	☐ Associate Degree	☐ Bachelor Degree
	☐ Graduate Degree	☐ PhD/Doctorate	☐ Unknown	☐ Other _____

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

ACTIVITY*: Check all that apply to this individual

☐ Employed	☐ Self-Employed	☐ Job Search	☐ Post-Secondary School
☐ Training/Education	☐ English as a second language	☐ GED/High School Equivalency	☐ Middle / Jr. High
☐ Disabled	☐ National Guard	☐ Military Reserves	☐ 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*: ☐ Male ☐Female	Relationship to the Primary Adult Caretaker*:

Race (optional, mark all that apply):	☐ American Indian or Alaskan Native	☐ Native Hawaiian or Pacific Islander	Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic
	☐ Asian ☐ Black	☐ White ☐ Other	

Highest Grade Completed*:	☐ Less Than High School/High School Equivalency	☐ High School/High School Equivalency	☐ Associate Degree	☐ Bachelor Degree
	☐ Graduate Degree	☐ PhD/Doctorate	☐ Unknown	☐ Other _____

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

ACTIVITY*: Check all that apply to this individual

☐ Employed	☐ Self-Employed	☐ Job Search	☐ Post-Secondary School
☐ Training/Education	☐ English as a second language	☐ GED/High School Equivalency	☐ Middle / Jr. High
☐ Disabled	☐ National Guard	☐ Military Reserves	☐ 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*:	Relationship to the Primary Adult Caretaker*:
____-____-_____	____/____/_____	☐ Male ☐ Female	

Citizenship Status*:	Race (optional, mark all that apply):				Ethnicity (optional):
☐Citizen ☐Non-citizen ☐ Qualified Alien	☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		☐ Hispanic ☐ Non-Hispanic
	☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ No
If your child is not receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

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*:	Relationship to the Primary Adult Caretaker*:
____-____-_____	____/____/_____	☐ Male ☐ Female	

Citizenship Status*:	Race (optional, mark all that apply):				Ethnicity (optional):
☐Citizen ☐Non-citizen ☐ Qualified Alien	☐ American Indian or Alaskan Native		☐ Native Hawaiian or Pacific Islander		☐ Hispanic ☐ Non-Hispanic
	☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ No
If your child is not receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

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*:	Relationship to the Primary Adult Caretaker*:
____-____-_____	____/____/_____	☐ Male ☐Female	

Citizenship Status*:	Race (optional, mark all that apply):				Ethnicity (optional):
☐Citizen ☐Non-citizen ☐ Qualified Alien	☐ American Indian or Alaskan Native	☐ Native Hawaiian or Pacific Islander			☐ Hispanic ☐ Non-Hispanic
	☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ 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?	☐Yes ☐ 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*:	Relationship to the Primary Adult Caretaker*:
____-____-_____	____/____/_____	☐ Male ☐Female	

Citizenship Status*:	Race (optional, mark all that apply):				Ethnicity (optional):
☐Citizen ☐Non-citizen ☐ Qualified Alien	☐ American Indian or Alaskan Native	☐ Native Hawaiian or Pacific Islander			☐ Hispanic ☐ Non-Hispanic
	☐ Asian	☐ Black	☐ White	☐ Other	

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ 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? ☐ Yes ☐ 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?*	☐ Yes ☐ 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?	☐Yes ☐ 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?	☐Yes ☐ 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?* ☐ 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)
			☐ Yes ☐ No	☐ Yes ☐ No			$
			☐ Yes ☐ No	☐ Yes ☐ 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)
			☐ Yes ☐ No	☐ Yes ☐ No			$
			☐ Yes ☐ No	☐ Yes ☐ 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
	☐ Yes ☐ No	☐ Yes ☐ No			
	☐ Yes ☐ No	☐ Yes ☐ 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)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	☐ Yes ☐ No If yes, list amount: $_____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	☐ Yes ☐ 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)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments)	☐ Yes ☐ No If yes, list amount: $_____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	☐ Yes ☐ 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*: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐Post-Secondary Education ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐Certificate Program	Anticipated Completion Date*:
Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution*:	Type of Training*: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐Post-Secondary Education ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐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*: ☐ Permanent ☐Temporary	Is this Individual able to take care of the child(ren)?* ☐ Yes ☐ No	Physician Review Due Date, if applicable:	
Name*:		Disability Begin Date*:	Disability End Date:
Disability Type*: ☐ Permanent ☐Temporary	Is this Individual able to take care of the child(ren)?* ☐ Yes ☐ 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	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
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*
	☐Yes ☐No									
	☐Yes ☐No									
	☐Yes ☐No									
	☐Yes ☐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:_____

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	10+
85% SMI	$4,139	$5,112	$6,086	$7,059	$8,033	$8,215	$8,398	$8,581	+$4,160 per add. member

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. (By providing education/training or work schedules at re-determination and whenever my activity changes.)

4. I agree that I will provide job search logs as required by the County.

5. I agree that if I am in education/training (county option) that I will maintain satisfactory progress to remain eligible for child care assistance for this activity. Satisfactory progress is a GPA of at least a 2.0 or its equivalent or have academic standing consistent with the institution's graduation requirements.

6. I agree to notify my child care worker in writing at least ten (10) days BEFORE changing child care providers otherwise the county may not pay for my child care.

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

8. 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.

9. 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. I also understand that I must provide documentation from the IRS or other government agency to verify my self-employment status.

10. I understand that if child care is provided for my employment activity then the taxable gross wages divided by the number of hours I use child care for my employment must equal at least the current federal minimum wage in order to continue receiving child care.

11. I agree that if my county requires child support enforcement I will cooperate with the child support enforcement office for any child that has an absent parent regardless of whether they receive child care assistance.

12. 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.

13. 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.

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. PARENTAL FEE:
    a. I agree to pay the parental fee listed on my child care authorization notice and that it is due to the provider on the first day of each month.
    b. I understand that my parental 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.

Denver County CCAP
CHILD CARE ASSISTANCE PROGRAM
P: 720-944-KIDS F: 720-944-3330 1200 FEDERAL BOULEVARD, DENVER, CO 80204 WWW.DENVERCCAP.ORG

2015-2016 DPS Non-School Days

Please complete this form indicating the "Non-school Days" for which you are requesting full-time child care for any school-aged child.

School District/Name:_____

Child's Name:_____

Place an "X" by each Non-school day for which you are requesting child care coverage for your school-aged child.
PT= Part-time Care (Less than 5 hours) FT=Full-time care (More than 5 hours)

PT	FT		PT	FT	
___	___	September 7, 2015 (Labor Day)	___	___	February 15, 2016 (President's Day)
___	___	October 19, 2015 (Planning Day)	___	___	February 29, 2016 (Planning/Assessment Day)
___	___	October 20, 2015 (Assessment Day)	___	___	March 28-April 1, 2016 (Spring Break)
___	___	November 2, 2015 (Parent/Teacher Conferences)	___	___	April 11, 2016 (Planning/Assessment Day)
___	___	November 23-27, 2015 (Fall Break)	___	___	May 30, 2016 (Memorial Day)
___	___	December 21, 2015-January 5, 2016 (Winter Break)	___	___	June 3, 2016 (Last Day of School/Half Day)
___	___	January 18, 2016 (Martin Luther King, Jr. Day)			

____ **My child does not follow this schedule**

If your child's school schedule does not follow the Denver Public Schools calendar, please provide a copy of your child's school calendar indicating for which days child care is requested.

Summer Break:

Please indicate the child's schedule for summer: From:_____ Through:_____

____ Part Time ____ Full Time ____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri

I will inform you before any schedule changes that may be needed. By signing this form, I understand that I may not qualify for CCAP services due to a change in circumstances.

Parent/Caretaker Printed Name:_____ SSN:_____-_____-_____

Parent/Caretaker Signature:_____ Date:_____

Denver County
CCAP
CHILD CARE ASSISTANCE PROGRAM
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2016-2017 DPS Non-School Days

Please complete this form indicating the "Non-school Days" for which you are requesting full-time child care for any school-aged child.

School District/Name:_____

Child's Name:_____

Place an "X" by each Non-school day for which you are requesting child care coverage for your school-aged child.
PT= Part-time Care (Less than 5 hours) FT=Full-time care (More than 5 hours)

PT	FT		PT	FT	
___	___	September 5, 2016 (Labor Day)	___	___	February 3, 2017 (Planning/Assessment Day)
___	___	October 27, 2016 (Planning Day)	___	___	February 20, 2017 (President's Day)
___	___	October 28, 2016 (Assessment Day)	___	___	March 27-March 31, 2017 (Spring Break)
___	___	November 4, 2016 (Parent/Teacher Conferences)	___	___	April 3, 2017 (Planning/Assessment Day)
___	___	November 21-25, 2016 (Fall Break)	___	___	May 29, 2017 (Memorial Day)
___	___	December 22, 2016-January 6, 2017 (Winter Break)	___	___	June 2, 2017 (Last Day of School/Half Day)
___	___	January 16, 2017 (Martin Luther King, Jr. Day)			

____ **My child does not follow this schedule**

If your child's school schedule does not follow the Denver Public Schools calendar, please provide a copy of your child's school calendar indicating for which days child care is requested.

Summer Break:

Please indicate the child's schedule for summer: From: _____ Through: _____

____ Part Time ____ Full Time ____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri

I will inform you before any schedule changes that may be needed. By signing this form, I understand that I may not qualify for CCAP services due to a change in circumstances.

Parent/Caretaker Printed Name: _____ SSN: _____-_____-_____

Parent's Signature: _____ Date: _____

Denver County
CCAP
CHILD CARE ASSISTANCE PROGRAM
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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

Denver County
CCAP
CHILD CARE ASSISTANCE PROGRAM
P: 720-944-KIDS F: 720-944-3330 1200 FEDERAL BOULEVARD, DENVER, CO 80204 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 **60 days statewide** of subsidized childcare for job searching in a 12-month period. The 12-month period of time begins with the first day of job search activity. My first day of job search will be _____.

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, days 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 60 days of job search.

3. I will be job searching (circle) Monday Tuesday Wednesday Thursday Friday each week. I understand that I must inform my caseworker of any change to this schedule **before** it takes place or the days will count toward my 60 days of job search.

4. If I have scheduled care with a childcare provider and my child is absent that day, I understand that the absence counts toward my **60 day** maximum for the year.

5. I agree to submit my Job Search logs every **30 days** to my caseworker in order to continue receiving assistance.

6. I understand that **I must make a minimum of 10 contacts every 30 days.** If the job search logs that I turn in every 30 days do not have a minimum of 10 contacts, I understand that my case will be closed, and that I may have to pay for care that I used when I was not in an eligible activity.

7. I agree to notify my caseworker in writing as soon as possible after getting a job. 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.

Client Signature: _____ Date: _____

Caseworker Signature: _____ Date: _____

HH #: _____

Voter Registration Choice Form

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: _____

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)

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? (You will not receive a ballot by email). Yes ☐ No ☐

Email address

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).