For CCCAP Staff to Complete:	
Form Received Date:	**Case Number:**

Colorado Child Care Assistance Program (CCCAP)
Re-determination of Eligibility Form

Your current certification is ending and child care benefits will stop as of _____. Please complete and sign this re-determination form as soon as possible, or by _____. Without a signed re-determination form and required documents, we will be unable to determine your continued eligibility for CCCAP.

Definitions:

- **You** = The parent or primary guardian completing the application.
- **Primary Guardian** = An adult, not the parent, legally responsible for caring for a child.
- **Teen Parents** = a person under twenty-one (21) years of age who is financially contributing to the welfare of the child and is the parent, adoptive parent, step-parent, legal guardian, or person who is acting in “loco parentis,” has custody of the child(ren) for the period that care is requested and is in an eligible activity such as attending basic education, employment, self-employment, or job search.
- **Additional Guardian/Spouse** = A person who lives in your house that cares for your children and/or provides financial assistance and support. This is a person who is assuming the parent obligations for a minor, including protecting their rights and/or a person who is standing in the role of the parent of a minor without having gone through the formal adoption process.

Instructions:

- **This form must be submitted by the parent or primary guardian of the children needing child care.**
- **Completing this form does not guarantee continuing child care assistance past the dates identified above.**
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please provide all requested information listed on page 18 and as requested from your CCCAP caseworker.
- In order to avoid a delay in processing your redetermination and any additional follow up, please address each section and ensure that all information is completed and accurate.
- **Teen Parents:** Do not include information about your parents, even if you live with them.

If you have questions about how to complete this form, please contact your county CCCAP office.

TABLE OF CONTENTS

Section 1a: Contact Information for You, the Parent/Primary Guardian (REQUIRED)

Your Address:			Mailing Address: ☐ Same as your address?		
City:	State:	Zip Code:	City:	State:	Zip Code:
County:			County:		

Contact Information: *Complete at least one*	Your Email Address (**required**) *If this has changed, please notify your CCCAP worker*:	Primary Phone: Type: ◯ Home ◯ Cell ◯ Voice Message ◯ Work	Secondary Phone: Type: ◯ Home ◯ Cell ◯ Voice Message ◯ Work

Preferred Contact Method:
◯ Phone ◯ Email ◯ Mail

Section 1b: For re-determination purposes, do any of the following describe where you live?

◯ Living in hotelor motel ◯ Living in campground ◯ Living in shelter ◯ Living in someone else's home due to housing loss, economic struggles, etc. ◯ Living in substandard housing such as car, park, abandoned building, etc. ◯ Other temporary living situation (please explain): ◯ None apply

Date living situation began:	Anticipated end date (if known):

Section 2a: Household Information (REQUIRED)

Please list every person that lives in your home starting with you.

Last Name, First Name, Middle Initial	Gender (M/F)	Date of Birth	How related to you? (self, additional guardian/	If this person is a child, are you requesting care for this child?	Citizenship Status (only required for children requesting care):
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien[1]
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien
	Male Female			Yes No N/A	Citizen Non-Citizen Qualified Alien

[1] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Section 2b: New Adults in your Home

REQUIRED: Are any of the adults listed in **Section 2a** new to your household since you completed the last CCCAP application or redetermination form?

◯ Yes ◯ No

If YES, you're required to complete the following table: Use additional paper if necessary.

If NO, skip to section 2c.

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Military Status	Marital Status (see codes below)	Hispanic or Latino (Y/N)	Race(s): List all that apply (see codes below)
			◯ Active Military (serving full time) ◯ Military Reserves ◯ National Guard	◯ D ◯ M ◯ S ◯ P ◯ W	◯ Yes ◯ No	☐ A ☐ I ☐ B ☐ P ☐ H ☐ W
			◯ Active Military (serving full time) ◯ Military Reserves ◯ National Guard	◯ D ◯ M ◯ S ◯ P ◯ W	◯ Yes ◯ No	☐ A ☐ I ☐ B ☐ P ☐ H ☐ W

Marital Status Codes: D-Divorced, **M-**Married, **S-**Single, **P-**Separated, **W-**Widowed

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

Section 2c: New Children in your Home

REQUIRED: Are any of the **children** listed in **Section 2a** new to your household since you completed the last CCCAP application or redetermination form?

◯ Yes ◯ No

If YES, you're required to complete the following table: Use additional paper if necessary.
If NO, skip to section 2d.

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Date of Birth	Gender	Does this child have a disability or special care need?	Citizenship Status:
				◯ Male ◯ Female	◯ Yes ◯ No	◯ Citizen ◯ Non-Citizen ◯ Qualified Alien[1]
Hispanic or Latino? ◯ Yes ◯ No		Race(s): List all that apply (see codes below): ☐ A ☐ I ☐ B ☐ P ☐ H ☐ W		Immunization Status: (in accordance with Colorado Department of Public Health and Environment [CDPHE] guidelines): ◯ Yes, vaccinated ◯ No, in proces ◯ No, non-medical exemption ◯ No, medical exemption ◯ Other:		

Name of parent(s) outside of household who may have duty for child support:

Last: First:

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

[1] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Section 2c (continued): New Children in your Home

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Date of Birth	Gender	Does this child have a disability or special care need?	Citizenship Status:
				◯ Male ◯ Female	◯ Yes ◯ No	◯ Citizen ◯ Non-Citizen ◯ Qualified Alien[1]

Hispanic or Latino?	Race(s): List all that apply (see codes below):	Immunization Status: (in accordance with Colorado Department of Public Health and Environment [CDPHE] guidelines):
◯ Yes ◯ No	☐ A ☐ I ☐ B ☐ P ☐ H ☐ W	◯ Yes, vaccinated ◯ No, in proces ◯ No, non-medical exemption ◯ No, medical exemption ◯ Other:

Name of parent(s) outside of household who may have duty for child support:

Last: First:

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

[1] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Section 2c (continued): New Children in your Home

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Date of Birth	Gender	Does this child have a disability or special care need?	Citizenship Status:
				◯ Male ◯ Female	◯ Yes ◯ No	◯ Citizen ◯ Non-Citizen ◯ Qualified Alien[1]

Hispanic or Latino?	Race(s): List all that apply (see codes below):	Immunization Status: (in accordance with Colorado Department of Public Health and Environment [CDPHE] guidelines):
◯ Yes ◯ No	☐ A ☐ I ☐ B ☐ P ☐ H ☐ W	◯ Yes, vaccinated ◯ No, in proces ◯ No, non-medical exemption ◯ No, medical exemption ◯ Other:

Name of parent(s) outside of household who may have duty for child support:

Last: First:

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

[1] "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

Section 2d: Custody Arrangements

REQUIRED: Are there any children living in your household that are part of a Joint Custody agreement or another case? ◯ Yes ◯ No

If YES, you're required to complete the following table.
If NO, skip to section 3.

Child's Name	Joint Custody or another case	Date moved into custody arrangement
	◯ Joint Custody ◯ Another custody case (please explain):	
	◯ Joint Custody ◯ Another custody case (please explain):	
	◯ Joint Custody ◯ Another custody case (please explain):	

Section 3: There are other programs that can benefit you and your family.

So that we can connect you to those programs, please select one of the three options below for each program: I participate; I'd like to learn more; or I am not interested.

*If you select that you would like to learn more, you will be connected to those programs to complete their referral or application processes to see if you qualify.

Head Start/Early Head Start Education Programs: free, quality education for children 0 to 5 years old (***not available in all communities***).	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Early Intervention Colorado: developmental supports available at no cost for children birth up to 3 years old	◯ I participate ◯ I'm not interested ◯ I'd like to learn more because I am concerned about my birth up to 3-year-old child's development.
Preschool Special Education: education supports available at no cost for 3- to 5-year-olds	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Colorado Works/Temporary Assistance for Needy Families (TANF) Cash Assistance: cash assistance for those who qualify	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Food Assistance (SNAP): assistance buying food	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Women, Infants and Children (WIC) Food and Nutrition Program: food, nutrition, and breastfeeding supports for you and your 0-5-year-old child(ren)	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Medicaid/CHP+ Health Insurance Assistance: health coverage for those who qualify.	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Housing Choice Voucher or cash assistance: assistance paying my rent or utilities	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Low-Income Energy Assistance (LEAP): assistance paying my heating bill	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Refugee Medical Assistance: medical assistance for refugees	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Child Support Services: Services that make sure that children receive regular financial support from both parents.	◯ I participate ◯ I'd like to learn more ◯ I'm not interested

Section 4: Your Qualifying Activity

To be eligible for CCCAP, we need to determine your qualifying activity. Please include all accurate information in the following section. Verification of qualifying activity will be required.

Include the last thirty (30) days of pay stubs for verification; If the last 30 days does not represent your regular income, please submit additional pay stubs for an accurate eligibility determination.

***Note**: If any of your jobs started within the last 60 days, please provide an employer letter.*

Section 4a: (REQUIRED)

Select ALL that apply and complete all requested information for your selected activity or activities.

☐ **Employed**

Start Date:

Employer Name:

Address:

Phone:

Number of hours per week:

Do you have another job? ◯ Yes ◯ No

(If YES, answer the questions below):

Start Date:

Employer Name:

Address:

Phone:

Number of hours per week:

*If you have more than these two jobs, you may complete additional pages.

☐ Self-Employed

◯ as an LLC

◯ as an S-Corp

◯ Other:

Number of hours per week:

☐ **Not working**

When did you stop working? (if applicable):

☐ **Looking for a job**

Start date (if applicable):

☐ **On maternity/paternity leave**

Start Date:

Expected End Date:

☐ **Disabled** Start Date:

The disability is:

☐ Permanent

☐ Temporary: end date:

Are you able to take care of the child(ren)?

◯ Yes ◯ No

Physician Review Due Date (**if applicable**):

☐ **On strike**

Start Date:

Expected End Date:

☐ **On medical leave**

Start Date:

Expected End Date:

☐ **On a seasonal break**

Start Date:

Expected End Date:

Section 4b. (REQUIRED). Are you currently participating in training or education?

◯ Yes ◯ No

If YES, you're required to complete the table below. (VERIFICATION IS REQUIRED)
If NO, skip to Section 4c.

Name of Training/Education Institution:

Type of Training:	Effective Begin Date:	Anticipated Completion Date:	Number of Credits (if applicable):
◯ Adult Basic Education ◯ English As A Second Language (ESL) ◯ GED/High School Equivalency ◯ High School/Jr. High ◯ Job Skills Training ◯ Vocational or Trade School ◯ Certificate Program ◯ Post-Secondary Education (first bachelor's degree or less) Number of hours per week:			

Will this training/education result in a certificate/degree? ◯ Yes ◯ No

If YES, which type:

◯ High School Diploma/GED/High School Equivalency
◯ Associate's Degree
◯ Master's Degree
◯ Bachelor's Degree
◯ Ph.D./Doctorate
◯ Certificate in:

Section 4c (REQUIRED). Have you graduated within the last 12 months? ◯ Yes ◯ No

If YES, you're required to complete the table below.
If NO, skip to Section 5.

Degree obtained:

◯ High School Diploma/GED/High School Equivalency
◯ Associate's Degree
◯ Master's Degree
◯ Bachelor's Degree
◯ Ph.D./Doctorate
◯ Certificate in:

Section 4d (REQUIRED). Are you currently participating in a substance use disorder treatment program? ◯ Yes ◯ No

If YES, you're required to complete the table below.
If NO, skip to Section 5.

Individual Name:		Begin Date:	
Treatment Facility Name:		Anticipated End Date (if known):	

Treatment Program Type:

☐ Structured Outpatient (ASAM Level 2, Intensive Outpatient, IOP, ASAM Level 2.5, Partial Hospitalization, PHP, Day treatment)	☐ Highly structured residential (ASAM Level 3.5, clinically managed high-intensity residential services)
☐ Residential (ASAM Level 3.1, clinically managed low-intensity services, ASAM Level 3.3, clinically managed population-specific high intensity residential services, ASAM Level 3.2WM, withdrawal management - residential)	☐ Highly structured residential services with medical staff onsite (ASAM Level 3.7, inpatient, medically monitored intensive inpatient services, ASAM Level 3.7WM, withdrawal management with medical staff onsite)

Treatment Facility Address:

Street: State:
City: Phone Number:
Zip Code:

Hours Per Week:

☐ 6+, no overnight care
☐ 9+, no overnight care
☐ 24/7 residential care, including overnight

Section 5: Additional Guardian/Spouse Qualifying Activity

REQUIRED: Is there an additional guardian/spouse in your home? (If you are a teen parent, do not include your parents) ◯ Yes ◯ No

If YES, you're required to complete Sections 5a – 5c: (VERIFICATION IS REQUIRED)
If NO, skip to Section 6.

To be eligible for CCCAP, we need to determine your additional guardian/spouse's qualifying activity. Please include all accurate information in the following section. Verification of qualifying activity will be required.

Include the last thirty (30) days of pay stubs for verification; If the last 30 days does not represent your regular income, please submit additional pay stubs for an accurate eligibility determination.

***Note**: If any of your jobs started within the last 60 days, please provide an employer letter.*

Section 5a.

Select ALL that apply and complete all requested information for your selected activity or activities.

☐ **Employed**

Start Date:

Employer Name:

Address:

Phone:

Number of hours per week:

Do you have another job? ◯ Yes ◯ No

(If YES, answer the questions below):

Start Date:

Employer Name:

Address:

Phone:

Number of hours per week:

*If you have more than these two jobs, you may complete additional pages.

☐ Self-Employed

◯ as an LLC

◯ as an S-Corp

◯ Other:

Number of hours per week:

☐ **Not working**

When did you stop working? (if applicable):

☐ **Looking for a job**

Start date (if applicable):

☐ **On maternity/paternity leave**

Start Date:

Expected End Date:

☐ **Disabled** Start Date:

The disability is:

☐ Permanent

☐ Temporary: end date:

Are you able to take care of the child(ren)?

◯ Yes ◯ No

Physician Review Due Date (**if applicable**):

☐ **On strike**

Start Date:

Expected End Date:

☐ **On medical leave**

Start Date:

Expected End Date:

☐ **On a seasonal break**

Start Date:

Expected End Date:

Section 5b. Is the additional guardian/spouse currently participating in a training/ education activity? ◯ Yes ◯ No

If YES, you're required to complete the table below. (VERIFICATION IS REQUIRED)
If NO, skip to Section 5c.

Name of Training/Education Institution:

Type of Training:	Effective Begin Date:	Anticipated Completion Date:	Number of Credits (if applicable):
◯ Adult Basic Education ◯ English As A Second Language (ESL) ◯ GED/High School Equivalency ◯ High School/Jr. High ◯ Job Skills Training ◯ Vocational or Trade School ◯ Certificate Program ◯ Post-Secondary Education (first bachelor's degree or less) Number of hours per week:			

Will this training/education result in a certificate/degree? ◯ Yes ◯ No

If YES, which type:

◯ High School Diploma/GED/High School Equivalency
◯ Associate's Degree
◯ Master's Degree
◯ Bachelor's Degree
◯ Ph.D./Doctorate
◯ Certificate in:

Section 5c. Has the additional guardian/spouse graduated within the last 12 months? ◯ Yes ◯ No

If YES, you're required to complete the table below.
If NO, skip to Section 5.

Degree obtained:

◯ High School Diploma/GED/High School Equivalency
◯ Associate's Degree
◯ Master's Degree
◯ Bachelor's Degree
◯ Ph.D./Doctorate
◯ Certificate in:

Section 5d (REQUIRED). Is the additional guardian/spouse currently participating in a substance use disorder treatment program? ◯ Yes ◯ No

If YES, you're required to complete the table below.
If NO, skip to Section 6.

Individual Name:		Begin Date:	
Treatment Facility Name:		Anticipated End Date (if known):	

Treatment Program Type:

☐ Structured Outpatient (ASAM Level 2, Intensive Outpatient, IOP, ASAM Level 2.5, Partial Hospitalization, PHP, Day treatment)	☐ Highly structured residential (ASAM Level 3.5, clinically managed high-intensity residential services)
☐ Residential (ASAM Level 3.1, clinically managed low-intensity services, ASAM Level 3.3, clinically managed population-specific high intensity residential services, ASAM Level 3.2WM, withdrawal management - residential)	☐ Highly structured residential services with medical staff onsite (ASAM Level 3.7, inpatient, medically monitored intensive inpatient services, ASAM Level 3.7WM, withdrawal management with medical staff onsite)

Treatment Facility Address:

Street: State:
City: Phone Number:
Zip Code:

Hours Per Week:

☐ 6+, no overnight care
☐ 9+, no overnight care
☐ 24/7 residential care, including overnight

Section 6: Work/Self-Employment Income

REQUIRED: Do you or your additional guardian/spouse have work or self-employment income?

◯ Yes ◯ No

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)
If NO, skip to Section 7.

Individual Name:	How often paid?	Total earnings per pay period (including tips and commissions) ***before taxes***
		$
		$

Section 7: Court Ordered Child Support Paid Out

REQUIRED: Do you or your additional guardian/spouse make child support payments for any child(ren)?
◯ Yes ◯ No

If YES, you're required to complete the following table: (VERIFICATION OF COURT ORDER AND PAYMENT IS REQUIRED.)
If NO, skip to Section 8.

Name of person making payment	Name of child	Amount paid	How often paid?
		$	
		$	

Section 8: Child Support Received and/or Ordered

REQUIRED: Do you receive child support for any of your children? ◯ Yes ◯ No
REQUIRED: Has child support been ordered for any of your children? ◯ Yes ◯ No ◯ Not sure

If YES to either, you're required to complete the following table:
If NO to both, skip to Section 9a.

Child Name(s)	Is child support received?	Is child support ordered?	Amount of Child Support Paid	How often paid?	How is it paid? (Venmo, cash, check, family support registry [FSR], etc.)	Name of non-custodial parent
	◯ Yes ◯ No	◯ Yes ◯ No	$			
	◯ Yes ◯ No	◯ Yes ◯ No	$			

Section 9a: Other Income

You must report all income coming into your household so your CCCAP specialist can determine if it is countable when determining your eligibility.

Scan the list of "other income types" below.

REQUIRED: Do you or any household members have other types of income? ◯ Yes ◯ No

If you don't see your income type included in the list below, write it in in the "other" spaces at the bottom.

If YES, you're required to complete the information below for each person in your household that has other income:
If NO, skip to section 9b.

Your Other Income:

Your Other Income Type	Mark if Receiving	Begin Date	Expected End Date	Amount	How often is the income amount received? (weekly, monthly, annually, etc.)
Alimony/Maintenance	☐				
Cash Contributions	☐				
Gifts	☐				
"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	☐				
Social Security (Survivor's, Disability, Retirement)	☐				
Supplemental Security Income (SSI)	☐				
Unemployment Compensation	☐				
Veteran's Benefits	☐				
Other Income (List Type):					
Other Income (List Type):					

Additional Guardian/Spouse's Other Income:					
Additional Guardian/Spouse Other Income Type	**Mark if Receiving**	**Begin Date**	**Expected End Date**	**Amount**	**How often is the income amount received? (weekly, monthly, annually, etc.)**
Alimony/Maintenance	☐				
Cash Contributions	☐				
Gifts	☐				
"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	☐				
Social Security (Survivor's, Disability, Retirement)	☐				
Supplemental Security Income (SSI)	☐				
Unemployment Compensation	☐				
Veteran's Benefits	☐				
Other Income (List Type):					
Other Income (List Type):					

Child's Other Income
(Don't include child support covered in Section 8)

Child's Name:

Child(ren)'s Other Income Type	Mark if Receiving	Begin Date	Expected End Date	Amount	How often is the income amount received? (weekly, monthly, annually, etc.)
Alimony/Maintenance	☐				
Cash Contributions	☐				
Gifts	☐				
"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	☐				
Social Security (Survivor's, Disability, Retirement)	☐				
Supplemental Security Income (SSI)	☐				
Unemployment Compensation	☐				
Veteran's Benefits	☐				
Other Income (List Type):					
Other Income (List Type):					

COPY THIS PAGE AS NEEDED FOR ADDITIONAL GUARDIAN/SPOUSE OR CHILDREN RECEIVING OTHER INCOME

Page _____ of _____

Section 9b: Assets (resources, belongings, valuables, etc.)

If your countable assets are worth more than $1,000,000 then you may not be eligible for CCCAP.

(REQUIRED): Do you or your additional guardian/spouse have any liquid resources?
Liquid resources are cash assets that may include (but are not limited to): cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc. ◯ Yes ◯ No

If NO, answer the next question about non-liquid resources.
If YES, you're required to provide the amount of your liquid resources in dollars $ _____

REQUIRED: Do you or your additional guardian/spouse have any non-liquid resources?
Non-liquid resources are non-cash assets that may include (but are not limited to): licensed/ unlicensed automobile, RVs, real property, etc. ◯ Yes ◯ No

If NO, skip to Section 10.
If YES, you're required to provide the current dollar value of your non-liquid resources $ _____

Section 10: Employment/Training/School/Job Search Schedule

Please fill in your expected schedule. If there is an additional guardian/spouse, fill in schedules for both. If you have more than one job please list your work schedule for both jobs.

Example:	*Mon. 8:00a - 5:00p*	*Tues. 8:00a - 5:00p*	*Wed. 8:00a - 5:00p*	*Thurs. 8:00a - 3:00p*	*Fri. 8:00a - 5:00p*	*Sat. 8:00a - 12:00p*	*Sun. 8 a.m.- 5 p.m.*
YOUR SCHEDULE:	Monday	Tuesday	Wed.	Thursday	Friday	Saturday	Sunday
Work/Job Search							
Training/School							
Substance Use Disorder Treatment Program							

ADDITIONAL GUARDIAN/SPOUSE SCHEDULE:	Monday	Tuesday	Wed.	Thursday	Friday	Saturday	Sunday
Work/Job Search							
Training/School							
Substance Use Disorder Treatment Program							

If your schedule varies please explain:

Section 11: Children's Current Care Schedule (REQUIRED)

Please complete a row for each child needing care. Do not complete for children who do not need care. If there are changes to your child's care schedule you MUST inform your CCCAP specialist. If you need assistance identifying a provider, visit www.coloradoshines.com or call 877-338-2273.

Child Name:	Child In School (k-8th grade):	Grade and School Of Attendance:	**Child's Schedule: Please indicate the anticipated number of hours of care needed per day. If you have a non-traditional schedule, list the exact times that care is needed. This information is necessary, so we know how many hours you need covered by CCCAP.**							
			Provider License number, or Provider Name, Address and Phone number where the child is enrolled	Mon.	Tues.	Wed.	Thu.	Fri.	Sat.	Sun.
	◯ Yes ◯ No									

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

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:

Is this child enrolled in the Universal Preschool Program? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Child Name:	Child In School (k-8th grade):	Grade and School Of Attendance:	**Child's Schedule: Please indicate the anticipated number of hours of care needed per day. If you have a non-traditional schedule, list the exact times that care is needed. This information is necessary, so we know how many hours you need covered by CCCAP.**							
			Provider License number, or Provider Name, Address and Phone number where the child is enrolled	Mon.	Tues.	Wed.	Thu.	Fri.	Sat.	Sun.
	◯ Yes ◯ No									

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

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:

Is this child enrolled in the **Universal Preschool Program**? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Child Name:	Child In School (k-8th grade):	Grade and School Of Attendance:	**Child's Schedule: Please indicate the anticipated number of hours of care needed per day. If you have a non-traditional schedule, list the exact times that care is needed. This information is necessary, so we know how many hours you need covered by CCCAP.**							
			Provider License number, or Provider Name, Address and Phone number where the child is enrolled	Mon.	Tues.	Wed.	Thu.	Fri.	Sat.	Sun.
	◯ Yes ◯ No									

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

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:

Is this child enrolled in the Universal Preschool Program? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Child Name:	Child In School (k-8th grade):	Grade and School Of Attendance:	**Child's Schedule: Please indicate the anticipated number of hours of care needed per day. If you have a non-traditional schedule, list the exact times that care is needed. This information is necessary, so we know how many hours you need covered by CCCAP.**							
			Provider License number, or Provider Name, Address and Phone number where the child is enrolled	Mon.	Tues.	Wed.	Thu.	Fri.	Sat.	Sun.
	◯ Yes ◯ No									

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

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:

Is this child enrolled in the **Universal Preschool Program**? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Notice and Acknowledgement of Data Sharing

By signing this document, I acknowledge and agree that in order to participate in and receive benefits and services through the Colorado Child Care Assistance Program (“CCCAP”), that my local County Department of Human Services (the “County”) and the Colorado Department of Early Childhood (“CDEC”) may need to share information about me with any of the entities listed below:

- Any child care provider I may choose to use,
- Any other governmentally-administered assistance program – including any entity directly involved in the administration or delivery of said governmentally-administered assistance program – including, but not limited to, Head Start, Early Head Start, and the Colorado Universal Preschool Program.

I further acknowledge and agree that the County and CDEC may require information and documentation from the entities listed below to process my CCCAP application, to redetermine my eligibility, or to otherwise manage my CCCAP-related services. By signing this document I hereby authorize the entities listed below to release information about me to the County and CDEC in order to participate in and receive benefits and services through CCCAP:

- 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 other governmentally-administered assistance program – including any entity directly involved in the administration or delivery of said governmentally-administered assistance program – including, but not limited to, Head Start, Early Head Start, and the Colorado Universal Preschool Program.

LOW-INCOME CHILD CARE CLIENT RESPONSIBILITIES AGREEMENT

As a recipient of Colorado Child Care Assistance Program (CCCAP) Benefits, I agree to the following:

1. To notify my child care worker in writing within ten (10) calendar-days if my total household income exceeds 85% of the State Median Income (SMI) 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. Income amounts by household size can be found at cdec.colorado.gov.
2. To complete the re-determination process, including providing a complete re-determination packet and all required verification, when it is due, in order to maintain my CCCAP benefits.
3. I agree to provide my child care worker with immunization records for my child(ren) if they are not yet school-age and care is provided outside of my home by an unrelated, Qualified Exempt Child Care Provider.
4. To notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.
5. To use the State approved Attendance Tracking System (ATS) as designed to check my child(ren) in and out of child care on the days that my child(ren) attends child care. If my child care provider has a state approved ATS waiver, I will check my child(ren) in and out as instructed by my child care worker and/or provider.
6. To not share my Attendance Tracking System Personal Identification Number (PIN) with my child care provider or any other individual and to notify my child care worker if my child care provider asks for this information.
7. To pay the parent fee listed on my child care authorization notice to my child care provider in the month that care is received.
8. If my CCCAP case closes and less than thirty (30) days have passed from the date of closure before I have provided the verification needed to correct the reason for closure, services may resume as of the date the verification was received by the county. I also understand that I would be responsible for payment during the gap in service.

As a recipient of CCCAP benefits, I acknowledge the following:

1. If myself or any teen parent or additional guardian/spouse in my child care case 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.
2. If child care is provided for an employment or self-employment activity then the taxable gross wages divided by the number of hours worked must equal at least the current federal minimum wage in order to continue receiving child care. If a self-employment endeavor is less than twelve (12) months old and I am not making minimum wage, I will communicate this to my child care worker so

that I may utilize the Self-Employment Launch Period.

3. My parent fee is based on countable household income, household size and number of children in care and is subject to change. I will be notified of my new parent fee at the time of application or re-determination; or, when a reduction/increase of household parent fee occurs.
4. If I do not pay my parent fee or make acceptable payment arrangements with my child care provider, I will lose my child care benefits at re-determination and will not be able to receive child care assistance with another child care provider and/or through any other county.
5. If myself or an additional guardian/spouse in my child care case is found to have intentionally given false information by deed or omission, my child care household 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.

By signing this document, 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.

YOU MUST READ AND SIGN THIS PAGE

You must submit the following documentation with this form:

IF YOU'VE HAD A CHANGE IN ADDRESS YOU NEED TO INCLUDE VERIFICATION OF RESIDENCY WHICH MAY INCLUDE ONE OF THE FOLLOWING:

- A lease agreement
- A utility bill
- A mortgage statement
- A paycheck stub with your address listed on it

IF YOU OR ANOTHER CARETAKER ON YOUR CASE ARE EMPLOYED OR SELF-EMPLOYED, YOU NEED TO INCLUDE:

- For self-employed persons, a business ledger and copies of your total business earnings, your business expenditures for the last thirty (30) days, and your expected work schedule. (Please be aware that you must make a profit and you must meet the current Federal Minimum wage to remain eligible).
- Income verification and verification of your work schedule (your work schedule is only required if you are requesting care during the evening, overnight, or weekend hours). You must attach copies of all household members' pay stubs from the last thirty (30) days. Please be aware that you must meet the current Federal Minimum wage to remain eligible.
- If you just started a new job, you must provide a completed copy of the employment verification letter including: your start date, your wages, your schedule (if requesting care during the evening, overnight, or weekend hours), number of hours/days you work per week, how often you will be paid, and the date of your first paycheck.

IF YOU OR ANOTHER CARETAKER ON YOUR CASE ARE IN AN EDUCATION/TRAINING ACTIVITY, YOU NEED TO INCLUDE:

A letter from your education/training institution which confirms your enrollment. This may include verification that:

1. Identifies the program you are enrolled in; and,
2. Identifies when you are expected to complete the program.
3. Start and end dates of quarter, semester, or session;
4. Days/times of class (if requesting care during the evening, overnight, or weekend hours); and,
5. Number of credits.

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

Completion Checklist, did you:

☐ Complete redetermination	☐ Attach required pay stubs	☐ Attach employment verification letter (if new employment)
☐ Sign and date redetermination	☐ Attach all training information	☐ Attach verification of any other income
☐ Attach work, education/ training, or substance use disorder treatment program schedule (if requesting care during the evening, overnight, or weekend hours)	☐ Attach all education information	☐ Attach verification of residence (if you've experienced a change in address)

By signing this document, I/we certify that the information on this form is correct, to the best of my knowledge. I/we understand that failure to report changes or misreporting information may result in the recovery and/or discontinuance of my child care benefits. I have read and agree to the conditions above for receiving assistance with my child care costs.

Primary Adult Caretaker Signature:	Daytime Phone:	Date:

Other Adult Caretaker Signature:	Daytime Phone:	Date:

IMPORTANT REMINDERS:

A person found to have intentionally given false information by deed or omission cannot get child care assistance in Colorado for twelve (12) months for the first offense, twenty-four (24) months for the second offense, and permanently for the third offense. This crime is subject to prosecution under federal and state laws.

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

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

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

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

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

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

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 of Civil Rights
U.S. Department of Health & Human Services 1961 Stout Street
Room 08-148
Denver, CO 80294

Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697

Email: ocrmail@hhs.gov

Keep this page for your reference.