

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

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

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Section 3: Additional Individual in your Household * (Adult or Child) Complete for all adults and children in your household				
Last Name*:		First Name*:		Middle Initial:
Date of Birth*:	Age:	County Use Only		
		Birth date Verified: Not Available Pending Verbal Written		
		How Verified?		
Social Security Number (optional):		County Use Only		
		Identity Verified: Not Available Pending Verbal Written		
		How Verified?		
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		County Use Only		
Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien		Citizenship Verified: Not Available Pending Verbal Written		
		How Verified?		
Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married, Living w/Spouse <input type="checkbox"/> Married, Not Living w/Spouse (involuntarily) <input type="checkbox"/> Married, Not Living w/Spouse (voluntarily) <input type="checkbox"/> Significant Other <input type="checkbox"/> Single – Never Married <input type="checkbox"/> Widowed/Widower				
Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Race (optional, all that apply): <input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian or Pacific Islander		
Highest Grade Completed: <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown				
ACTIVITY* Check all that apply to this individual				
<input type="checkbox"/> Disabled	<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> GED/High School Diploma	
<input type="checkbox"/> Elementary School	<input type="checkbox"/> Teen Parent Education	<input type="checkbox"/> Job Search	<input type="checkbox"/> English as a second language	
<input type="checkbox"/> Training/Education	<input type="checkbox"/> Post-Secondary School	<input type="checkbox"/> Middle / Jr. High		
Do You? <input type="checkbox"/> Pay Child Support <input type="checkbox"/> Receive Child Support				

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

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

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Section 6: Applicant Employment and Wage Detail Information*: (If applicable)							
Complete Section 6 for each employed adult in your household and each place of employment							
Applicant Name*:			Employment Begin Date*:		Employment End Date:		
Are you the Primary Adult Caretaker*? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you Self-Employed*? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill out Section 9: Adult Caretaker Self-Employment Expenses Detail				
Employer Name*:				Doing Business As:			
Employer Address:			City*:		State:		ZIP:
How frequently are you paid*? (Select one)		Is this a New Job*? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, first Pay Date:		# Hours Worked*: Per:	Tips/Commissions/ Bonuses: \$ Per:	Gross Amount Before Taxes and Deductions*: \$ Per:	
<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	Is this Employment Temporary or Seasonal*? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated End Date:					
<input type="checkbox"/> Monthly	<input type="checkbox"/> Every 2 weeks						
<input type="checkbox"/> 2 times per month	<input type="checkbox"/> Every two months						
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-annually						
<input type="checkbox"/> Annually	<input type="checkbox"/> One Time						
County Use Only Verification Type	Pay Date	Frequency	Hours Worked	Hours Care Needed	Calculated Pay Rate Per Hour:	Tips/Commissions/ Bonuses:	Gross Income Before Taxes and Deductions:
Do you expect any breaks in your employment*? <input type="checkbox"/> Yes <input type="checkbox"/> No				Complete if yes:			
Maternity Leave*? <input type="checkbox"/> Yes <input type="checkbox"/> No				Leave Begin Date: _____ Date Returning: _____			
School Break/Temporary Layoff / Strike*? <input type="checkbox"/> Yes <input type="checkbox"/> No				Break Begin Date: _____ Break End Date: _____			

Section 7: Applicant Work Schedule*: Complete this section for each adult in the household marked "Employed or Self-Employed" in Activity							
Name*:					Effective Begin Date*:		Effective End Date:
Example:	Mon. (am/pm)	Tues. (am/pm)	Weds. (am/pm)	Thurs. (am/pm)	Fri. (am/pm)	Sat.	Sun.
Schedule:	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	0	0
Hours:	9	7	9	7	9	0	0
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule*							
# Hours*							
If your schedule varies please explain: _____							
County Use Only	Verified?	Not Available	Pending	Verbal	Written	How Verified?	

COPY THIS PAGE AS NEEDED FOR ADDITIONAL ADULT CARETAKERS AND/OR MULTIPLE EMPLOYERS
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Section 8: Other Income*: (If applicable) Complete information in Section 8 for <u>each person</u> 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?
Non-Work Income Types*: Refugee Cash Assistance Social Security (Survivor's, Disability, Retired) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Dividends from stocks and bonds Railroad Retirement Benefits Veteran's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income Americorp Income Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Income Types*: Housing voucher or cash assistance Colorado Works/TANF cash assistance Low-Income Energy Assistance (LEAP) Supplemental Security Income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Refugee Medical Assistance Medicaid/CHP+ Assistance Old Age Pension Food Assistance Other (Describe under Individual)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 9: Adult Caretaker Self-Employed Expenses Detail*: (If applicable) Complete Section 9 for each Adult Caretaker listed in Sections 2 and 3 who is Self-Employed				
Name*:			County Use Only	
Expense Date*:	Frequency*:	Expense Amount*:	Verified?	How Verified?
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	
			Not available Pending Verbal Verification Written Verification	

Section 10: Teen Parent Education Detail*: (If applicable) Complete Section 10 for each Teen Parent listed in Sections 2 and 3 who marked "Teen Parent Education" in Activity			
Name*:			
Number of Credits*:	School Name*:	School Type*: <input type="checkbox"/> GED/High School <input type="checkbox"/> Middle School / Jr. High	Anticipated Completion Date:
County Use Only	Verified?	Not Available	Pending
	Verbal	Written	How Verified?

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Section 11: Adult Caretaker Training/Education Detail*: (If applicable) Complete Section 11 for each Adult Caretaker listed in Sections 2 and 3 who marked "Training/Education" in Activity			
Name*:		Effective Begin Date*:	Effective End Date:
Number of Credits*:	Training Institution*:	Type of Training*: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> ESL <input type="checkbox"/> Post-Secondary Ed <input type="checkbox"/> GED/HS Diploma <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Certificate Program	Anticipated Completion Date*:
County Use Only	Verified?	Not Available	Pending Verbal Written How Verified?

Section 12: Applicant Education Schedule*: Complete this section for each adult in the household who marked "Education/Training" in Activity							
Name*:				Effective Begin Date*:	Effective End Date:		
Example:	<i>Mon. (am/pm)</i>	<i>Tues. (am/pm)</i>	<i>Weds. (am/pm)</i>	<i>Thurs. (am/pm)</i>	<i>Fri. (am/pm)</i>	<i>Sat.</i>	<i>Sun.</i>
Schedule:	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	0	0
Hours:	9	7	9	7	9	0	0
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule*							
# Hours*							
If your schedule varies please explain: _____							
County Use Only	Verified?	Not Available	Pending	Verbal	Written	How Verified?	

Section 13: Adult Caretaker Disability Detail*: (If applicable) Complete Section 13 for each Adult Caretaker listed in Sections 2 and 3 who marked "Disabled" in Activity			
Name*:		Disability Reported Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Review Due Date, if applicable:	
Is this Individual able to take care of children*? <input type="checkbox"/> Yes <input type="checkbox"/> No	County Use Only		How Verified?
	Verified?	Not Available	Pending Verbal Written

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Section 14: Child Disability Detail*: (If applicable) Complete Section 14 for each child in your household in Section 3 who marked "Disabled" in Activity			
Name*:		Disability Reported Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Review Due Date, if applicable:	
County Use Only	Verified?	Not Available	Pending Verbal Written
			How Verified?

Section 15 : Adult Caretaker Paying Child Support Detail*: (If applicable) Complete Section 15 for each Adult Caretaker in Sections 2 and 3 who marked "Pays Child Support" in Activity			
Name*:		Effective Begin Date*:	Effective End Date:
Docket/Court Case #*:	Recipient Name*:	How often is the amount paid*?	Amount of Court Ordered Child Support Paid*:
County Use Only	Verified?	Not Available	Pending Verbal Written
			How Verified?

Section 16 : Child Support Received Detail*: (If applicable) Complete Section 16 for each child listed in Section 3 who receives Child Support payments and/or has an absent parent.			
Child's Name*:		Is Child Support Court Ordered*? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Receive Child Support*? <input type="checkbox"/> Yes <input type="checkbox"/> No
Docket/Court Case #*:	Name of Absent Parent:	Amount of Court Ordered Child Support received*:	How often is the amount received*?
County Use Only	Verified?	Not Available	Pending Verbal Written
			How Verified?

Section 17: Note: You may reside in a county that requires Child Support Cooperation in order to receive Child Care Assistance Benefits.			
<ul style="list-style-type: none"> If your county requires this you must cooperate for any child with an absent parent regardless of child care eligibility unless there is good cause. For more details, please contact your local county Child Care Assistance Program office. 			
County Use Only			
Non-Custodial Parent Name:		SSN #:	
Non-Custodial Parent DOB:	State ID:		
Visitation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Open Child Support Case? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paying? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Good Cause? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain			

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Section 20: Child's Care Schedule* - Complete Section 20 for each child in Section 5 who you indicated "yes, you are requesting care"							
NOTE: Please attach a copy of each school-aged child's school calendar/schedule*							
Child's Name*:				Effective Begin Date*:		Effective End Date:	
Provider Name*:							
Provider Address*:							
Example:	<i>Mon. (am/pm)</i>	<i>Tues. (am/pm)</i>	<i>Weds. (am/pm)</i>	<i>Thurs. (am/pm)</i>	<i>Fri. (am/pm)</i>	<i>Sat.</i>	<i>Sun.</i>
Schedule:	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	8:00 - 3:00	8:00 - 5:00	0	0
Hours:	9	7	9	7	9	0	0
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule*							
# Hours*							
County Use Only	Child's Age at time of application:			Care Level at time of Application:			

COPY THIS PAGE AS NEEDED FOR SCHEDULES.

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Authorization to Supply Information

I/We hereby authorize the _____ County Department of Social/Human Services, in the course of administering the social services program, to supply information obtained directly from me or from any other person, agency, or institution which provided information to the county department with my written consent.

I/We understand that:

The county department is authorized to release the following information:

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

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

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

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

Signature of Primary Adult Caretaker: _____ Date: _____

Signature of Other Adult Caretaker: _____ Date: _____

Authorization to Release Information

I/We 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/WE also allow inspection and reproduction of records in their possession pertaining to me by any authorized representative of the county department. I/We release the person, agency, or institution from any and all liability for supplying such information.

- Any child care provider I/We may choose to use;
- Any employer for whom I/We work;
- Any entity or person who is able to verify self-employment;
- Any school or training institution I/We may be attending;
- Any other person, agency or institution that may be pertinent, including housing authorities.

Signature of Primary Adult Caretaker: _____ Date: _____

Signature of 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.

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.

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(ies) indicated in Section 2, 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.

You must use your CCAP card to check the child(ren) in and out of care daily or your child care assistance case will close and you will be responsible for payment of the child care costs.

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**
633-17th St, 13th Floor
Denver, CO 80202
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.

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

DOES THIS APPLY TO YOU?	What you need to submit	Other Notes	A Checklist for Your Use
YOU OR OTHER ADULTS IN THE HOUSEHOLD ARE WORKING:	All adult caretakers' paystubs from the last 3 months; Employer's Name; Address; Phone number; and exact work schedule(s)	Records for each job are required, if you (or other household members) have more than one job.	
YOU OR OTHER ADULTS ARE SELF-EMPLOYED:	Verification of Self-Employment status. Self-employment business ledger and copies of your total business earnings and expenditures for the last 3 months	Records for each self-employment activity are required, if you (or other household members) have more than one source of self-employment income.	
YOU OR OTHER ADULTS IN THE HOUSEHOLD JUST STARTED YOUR JOB:	Provide a completed copy of the employment verification letter including: your start date, your wages, your exact schedule, number of hours/days you work per week, how often you will be paid, and the date of your first paycheck.	Save your paystubs because you will need to submit three months worth of paystubs once you have them available.	
YOU LOSE YOUR JOB / OR YOU ARE LOOKING FOR A JOB:	A letter from your employer stating your last date of work and last paycheck date. Proof of job search activities as required by your county child care office.	Job Search Child Care is available on a LIMITED basis and you must have prior approval to use child care services for Job Search.	
YOU PAY CHILD SUPPORT TO SOMEONE OUTSIDE YOUR HOUSEHOLD:	Court documents verifying the court order and verification of the amount paid and how often this is paid.	This payment may be deducted from your gross, countable income.	
YOU HAVE NON-WORK OR OTHER INCOME FROM ANY SOURCE:	Proof of source, amount and frequency of payment. Include court documents, if applicable.	See Section 7 of Application for types of Income that may be included.	
YOU ARE ATTENDING SCHOOL OR TRAINING:	A letter from your education/training institution which (1) Verifies you are enrolled and making satisfactory progress. (2) Identifies the program you are enrolled in, and (3) Identifies when you are expected to complete the program. (4) Start and end dates of quarter, semester, or session; (5) Days/time of class and (6) Number of credits.	Not all counties provide child care while attending school or training. Check with your county for its policy.	
YOU HAVE CHOSEN A PROVIDER AND YOU HAVE CHILDREN REQUESTING CARE:	Name/Address of Provider Verification of each child's identification, birth date, citizenship, and immunization records	Your county can assist you with selecting a provider and obtaining the documents needed to participate in CCAP. You must have prior approval for payment to be made to the provider. You are responsible for full payment to the provider until that approval is completed.	
YOUR COUNTY NEEDS VERIFICATION OF THE ADDRESS OF YOUR RESIDENCE, REPORTED ON YOUR APPLICATION (IN SECTION 1)	You must provide one or more of the following: rent receipt/lease copy; mortgage statement; automobile registration; utility or other bill; verification from other county offices, other government agencies, education/training institutions; voter registration; or a statement from the lease holder/renter	You must verify the address reported on your application; the county can verify that address is within the county.	
YOUR COUNTY NEEDS AN ALTERNATE CONTACT FOR YOU BESIDES YOUR ADDRESS	Home Phone Work Phone Mobile Phone E-mail address Emergency Contact		

Keep this page for your use.