

Application for Child Care Services

NOTE: Shaded Areas For County Use Only

All Items Marked with (*)MUST be completed

Confidentiality Set: CWCC:	Primary Adult State ID:
Assigned to Caseload*:	CHATS Case # Legacy #
Date Application Received*:	Intake Completed By:

Completion of this application does not guarantee that you will receive child care assistance.

- All eligibility criteria must be met for you to qualify and receive assistance.
- Please provide all requested information (see Page 17 for additional information you must provide). Missing information will delay your application (*=required information).

Teen Parents: Do not include information about your parents even if you live with them.

Section 1: Applicant Information			Are you the Primary Adult Caretaker*? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please also complete Section 2		
Application Date*:			First name*:		
Last Name*:			Middle Initial:		
Residence Address*:			Mailing Address*: <input type="checkbox"/> Same as residence		
City*:	State:	Zip*:	City*:	State:	Zip*:
County*:			County*:		
Language preference of the household:			Address Verification:		
Contact Information: Please complete at least one of these		Home Phone: () Best Time to Call:	Work Phone: () Ext Best Time to Call:		Mobile Phone: () Best Time to Call:
Email Address:		Emergency Contact Number: () Ext Emergency Contact Name (Required with #):			
Preferred Method of Contact Listed*: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mail <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Email					
Other Information:					
Mark below regarding the benefits your household may be receiving:					
Housing Assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No		TANF? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Food Assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No If No, would you like to receive Food Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No		LEAP / SSI / OAP / Refugee Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Case Worker Only:					
Client Search Completed:			Other Cases:		

Section 2: Primary Adult Caretaker (same as Applicant, Section 1) PA				
Last Name*:		First Name*:		Middle Initial:
Date of Birth*:		Age:		Verification:
Social Security Number (optional):			Identity Verified:	
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female			Verification:	
Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien			Verification:	
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 you - fill out detail section (#) for each activity)				
<input type="checkbox"/> Disabled (9/11)	<input type="checkbox"/> Receive Child Support (14)	<input type="checkbox"/> Employed (6)	<input type="checkbox"/> Self-Employed (6+8)	
<input type="checkbox"/> Elementary School (16)	<input type="checkbox"/> Teen Parent Education (15)	<input type="checkbox"/> Job Search (12)	<input type="checkbox"/> Other Income (Non-work income) (7)	
<input type="checkbox"/> Training/Education (10)	<input type="checkbox"/> Post-Secondary School (10)	<input type="checkbox"/> Pay Child Support (13)	<input type="checkbox"/> English as a second language (10)	
<input type="checkbox"/> GED/High School Diploma (10)	<input type="checkbox"/> Middle / Jr. High (15)			

Section 3: Other Individuals in your Household (Adults and Children)				Rel
Complete Section 3 for every adult and child in your Household				Ch #
Last Name*:		First Name*:		Middle Initial:
Date of Birth*:		Age:		Verification:
Social Security Number (optional):			Identity Verified:	
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female			Verification:	
Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien			Verification:	
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 - fill out detail section (#)for each activity)				
<input type="checkbox"/> Disabled (9/11)	<input type="checkbox"/> Receives Child Support (14)	<input type="checkbox"/> Employed (6)	<input type="checkbox"/> Self-Employed (6+8)	
<input type="checkbox"/> Elementary School (16)	<input type="checkbox"/> Teen Parent Education (15)	<input type="checkbox"/> Job Search (12)	<input type="checkbox"/> Other Income (Non-work income) (7)	
<input type="checkbox"/> Training/Education (10)	<input type="checkbox"/> Post-Secondary School (10)	<input type="checkbox"/> Pays Child Support (13)	<input type="checkbox"/> English as a second language (10)	
<input type="checkbox"/> GED/High School Diploma (10)	<input type="checkbox"/> Middle / Jr. High (15)			

Section 3: Other Individuals in your Household (Adults and Children)			Rel
			Ch #
Last Name*:		First Name*:	Middle Initial:
Date of Birth*:	Age:	Verification:	
Social Security Number (optional):		Identity Verified:	
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		Verification:	
Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien		Verification:	
Marital Status (optional): <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 - fill out detail section for each activity marked)			
<input type="checkbox"/> Disabled (9/11)	<input type="checkbox"/> Receives Child Support (14)	<input type="checkbox"/> Employed (6)	<input type="checkbox"/> Self-Employed (6+8)
<input type="checkbox"/> Elementary School (16)	<input type="checkbox"/> Teen Parent Education (15)	<input type="checkbox"/> Job Search (12)	<input type="checkbox"/> Other Income (Non-work income) (7)
<input type="checkbox"/> Training/Education (10)	<input type="checkbox"/> Post-Secondary School (10)	<input type="checkbox"/> Pays Child Support (13)	<input type="checkbox"/> English as a second language (10)
<input type="checkbox"/> GED/High School Diploma (10)	<input type="checkbox"/> Middle / Jr. High (15)		

Section 3: Other Individuals in your Household (Adults and Children)			Rel
			Ch #
Last Name*:		First Name*:	Middle Initial:
Date of Birth*:	Age:	Verification:	
Social Security Number (optional):		Identity Verified:	
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		Verification:	
Citizenship Status*: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien		Verification:	
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- fill out detail section for each activity (#)marked)			
<input type="checkbox"/> Disabled (9/11)	<input type="checkbox"/> Receives Child Support (14)	<input type="checkbox"/> Employed (6)	<input type="checkbox"/> Self-Employed (6+8)
<input type="checkbox"/> Elementary School (16)	<input type="checkbox"/> Teen Parent Education (15)	<input type="checkbox"/> Job Search (12)	<input type="checkbox"/> Other Income (Non-work income) (7)
<input type="checkbox"/> Training/Education (10)	<input type="checkbox"/> Post-Secondary School (10)	<input type="checkbox"/> Pays Child Support (13)	<input type="checkbox"/> English as a second language (10)
<input type="checkbox"/> GED/High School Diploma (10)	<input type="checkbox"/> Middle / Jr. High (15)		

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS Page _____ of _____

Section 4: Relationship Detail*	Complete for all individuals in Sections 2 and 3
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Primary Adult Name:		Relationship: Self	Individual:	Relationship to Primary Adult:
Individual:	Relationship to Primary Adult:	Individual:	Relationship to Primary Adult:	Relationship to Primary Adult:
Individual:	Relationship to Primary Adult:	Individual:	Relationship to Primary Adult:	Relationship to Primary Adult:
Individual:	Relationship to Primary Adult:	Individual:	Relationship to Primary Adult:	Relationship to Primary Adult:
Verification:				

Section 5: Children 's Care Request and Immunizat ion Records* (Complete for all children in Section 3)

Child Name:	Care Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:	
Child Name:	Care Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:	
Child Name:	Care Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:	
Child Name:	Care Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:	
Child Name:	Care Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:	

Case Worker Notes Section A: Primary Activities/ CHATS Windows Checklists - COUNTY USE ONLY

CWCC Case Notes:	Confidentiality Set:
Household Members	CHATS Activity Windows :
Primary Adult Caretaker/ Other Adult Activities:	<input type="checkbox"/> Employment & Wage/Self Employment <input type="checkbox"/> Self Employment Expenses <input type="checkbox"/> Other Income <input type="checkbox"/> Teen Parent Education <input type="checkbox"/> Parent Training/Education <input type="checkbox"/> Parent Disability <input type="checkbox"/> Child Support Deduction <input type="checkbox"/> Confidentiality <input type="checkbox"/> Child Support Enforcement <input type="checkbox"/> Job Search <input type="checkbox"/> Parent Schedule (Optional)
Child Activities:	<input type="checkbox"/> Child Disability <input type="checkbox"/> Elementary School (Schedule)

Section 6: Employment and Wage Detai l Information:

Complete Section 6 for each employed adult and each place of employment in your household- Adults in Section 3. Includes employment through CO WORKS and CO HIRE

Applicant*:	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 Self-Employment Expenses Section 8	

Employer Name*:					DBA:		
Employer Address:			City*:		State:		ZIP:
How frequently are you paid*?			Is this a New Job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, first Pay Date:		# Hours Worked*:	Tips/Commissions/ Bonuses: \$	Gross Amount Before Taxes and Deductions*: \$
<input type="checkbox"/> Hourly	<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"/> Every two months		Per:	Tips/Commissions/ Bonuses:	Gross Amount Before Taxes and Deductions*:
<input type="checkbox"/> 2 times per month	<input type="checkbox"/> Every two months		<input type="checkbox"/> Semi-annually				
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-annually		<input type="checkbox"/> One Time				
<input type="checkbox"/> Annually	<input type="checkbox"/> One Time						
Verification Type*	Pay Date*	Frequency*	Hours Worked*	Hours Care Needed	Calculated Pay Rate Per Hour:	Tips/Commissions/ Bonuses:	Gross Amount Before Taxes and Deductions*:
Do you expect any breaks in your employment:							
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: _____	
Verification*: <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>							

Section 6A: Applicant Work Schedule Complete this section for each adult in the household in Sections 2 and 3 that is marked "Employed or Self-Employed" in Activity							
Name:					Effective Begin Date*:		Effective End Date:
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
Verification:							

Section 6: Employment and Wage Information							
Name*:			Employment Begin Date*:		Employment End Date:		
			Is This Individual Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in Self-Employment Expenses Section 8				
Employer Name*:					DBA:		
Employer Address:			City*:		State:		ZIP:
How frequently is this individual paid*?			Is This a New Job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, first Pay Date:		# Hours Worked*:	Tips/Commissions/ Bonuses:	Gross Amount Before Taxes and Deductions*:
<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly						

CDHS Child Care Application Form (revised 6-2010)

<input type="checkbox"/> Monthly		<input type="checkbox"/> Every 2 weeks			\$	\$	
<input type="checkbox"/> 2 times per month		<input type="checkbox"/> Every two months		Is this temporary or Seasonal? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated End Date:	Per:	Per:	Per:
<input type="checkbox"/> Quarterly		<input type="checkbox"/> Semi-annually					
<input type="checkbox"/> Annually		<input type="checkbox"/> One Time					
Verification Type	Pay Date*	Frequency*	Hours Worked*	Hours Care Needed	Rate Per Hour:	Tips/Commissions/Bonuses:	Gross Amount Before Taxes and Deductions*:

Do you expect any breaks in your employment:

Maternity Leave? Yes No Leave Begin Date: _____ Date Returning: _____

School Break/Temporary Layoff / Strike? Yes No Break Begin Date: _____ Break End Date: _____

Verification*:

Section 6A: Adult Work Schedule Complete Section 6A for each adult in your household in Sections 2 and 3 that is marked "Employed or Self-Employed" in Activity							
Individual*:					Effective Begin Date*:		Effective End Date:
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
Date Change Reported:		Verification:					

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS AND/OR MULTIPLE EMPLOYERS
 Page _____ of _____

Section 7: Other Income Complete information in Section 7 for each adult in your household with "Other Income" in Activity or a "Yes" answer in the Types below

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	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
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
Individual:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)			
	Income Source (from above):	Gross Amount	How Often is this income received?			
Individual:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)			
	Income Source (from above):	Gross Amount	How Often is this income received?			
Individual:	Effective Begin Date*:	Effective End Date:	Docket/Court Case # (if applicable)			
	Income Source (from above):	Gross Amount	How Often is this income received?			
Verification*:						

Section 8: Self-Employed Expenses Detail (Complete Section 8 for each adult in your household in Sections 2 and 3 that are Self-Employed)

Name:				
Expense Date:	Frequency:	Expense Amount:	Verified:	How Verified:

Verification:

Section 8: Self-Employed Expenses Detail

Name:				
Expense Date:	Frequency:	Expense Amount:	Verified:	How Verified:

Verification:

Section 9: Teen Parent Education Detail Complete Section 9 for each teen parent in your household in Sections 2 and 3 that is 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:

Verification:

Section 9: Teen Parent Education Detail

Name*:			
Number of Credits*:	School Name:	School Type*: <input type="checkbox"/> GED/High School <input type="checkbox"/> Middle School / Jr. High	Anticipated Completion Date:

Verification:

Section 10: Adult Training/Education Detail : (Complete Section 10 for each adult in your household in Sections 2 and 3 that are marked "Training/Education" in Activity)

Name*:	Effective Begin Date*:	Effective End Date:
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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:
Verification:			

Section 10: Adult Training/Education Detail :

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:
Verification:			

Section 11: Adult Disability Detail Complete Section 11 for each adult in your household in Sections 2 and 3 that are marked "Disabled" in Activity

Name*:		Disability Reported Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Review Due Date:	
Is this Individual able to take care of children*? <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:		

Section 11: Adult Disability Detail

Name*:		Disability Reported Date*:	Disability End Date:
Disability Type*: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Review Due Date:	
Is this Individual able to take care of children*? <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:		

Section 12: Child Disability Detail Complete Section 11 for each child in your household in Section 3 that is marked "Disabled" in Activity

Name*:	Disability Reported Date*:	Disability End Date:
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Describe Additional Care Needs:	Intervention Type:	Review Due Date:
	<input type="checkbox"/> Level 1 - Low <input type="checkbox"/> Level 2 - Moderate <input type="checkbox"/> Level 3 - High <input type="checkbox"/> Level 4 - Intense	
Verification:		

Section 12: Child Disability Detail :		
Name*:	Disability Reported Date*:	Disability End Date:
Describe Additional Care Needs:	Intervention Type:	Review Due Date:
	<input type="checkbox"/> Level 1 - Low <input type="checkbox"/> Level 2 - Moderate <input type="checkbox"/> Level 3 - High <input type="checkbox"/> Level 4 - Intense	
Verification:		

Section 13 : Paying Child Support Detail (Complete this Section for each adult in your household in Sections 2 and 3 that is marked "Pays Child Support" in Activity)			
Name*:		Effective Begin Date*:	Effective End Date:
Docket/Court Case # *:	Amount of Court Ordered Child Support Paid*:	How often is the amount paid*?	Receiver's Name*:
Verification: ACSES results			

Section 13 : Paying Child Support Detail			
Name*:		Effective Begin Date*:	Effective End Date:
Docket/Court Case # *:	Amount of Court Ordered Child Support Paid*:	How often is the amount paid*?	Receiver's Name*:
Verification: ACSES results			

Section 14 : Receiving Child Support Detail Complete Section 14 for each child in your household in Section 3 that receive Child Support payments and/or have an absent parent.			
Name*:		Is Child Support Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Child Support Received? <input type="checkbox"/> Yes <input type="checkbox"/> No
Docket/Court Case # *:	Name of Absent Parent:	Amount of Court Ordered Child Support Paid*:	How often is the amount paid*?

Verification:
ACSES results

Section 14 : Receiving Child Support Detail

Name*:		Is Child Support Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Child Support Received? <input type="checkbox"/> Yes <input type="checkbox"/> No
Docket/Court Case # *:	Name of Absent Parent:	Amount of Court Ordered Child Support Paid*:	How often is the amount paid*?

Verification:
ACSES results

Note: You may reside in a county that requires Child Support Enforcement participation in order to receive Child Care Assistance Benefits. 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.

Good Cause Verification:

Section 15: Job Search Detail (Complete Section 12 for each adult in the household in Sections 2 and 3 that is marked "Job Search" in Activity)

Name*:	Effective Begin Date*:	Effective End Date:
Job Search Activities		

Verification:

Section 15: Job Search Detail

Name*:	Effective Begin Date*:	Effective End Date:
Job Search Activities		

Verification:

Section 16: Child 's Care Schedule Complete this section for each Child requesting care ("yes" in Section 5)

Child's Name*:	Effective Begin Date*:		Effective End Date:				
Provider Name*:							
Provider Address*:							
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							

Provider / Care Level / Verification:

Section 16: Child 's Care Schedule							
Child's Name*: Provider Name*: Provider Address*:					Effective Begin Date*:	Effective End Date:	
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
Provider / Care Level / Verification							

Section 16: Child 's Care Schedule							
Child's Name*: Provider Name*: Provider Address*:					Effective Begin Date*:	Effective End Date:	
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
Provider / Care Level / Verification							

Section 16: Child 's Care Schedule							
Child's Name*: Provider Name*: Provider Address*:					Effective Begin Date*:	Effective End Date:	
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
Provider / Care Level / Verification							

Section 16: Child 's Care Schedule							
Child's Name*: Provider Name*: Provider Address*:					Effective Begin Date*:	Effective End Date:	
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Schedule							
# Hours							
Provider / Care Level / Verification							

COPY THIS PAGE AS NEEDED FOR ADDITIONAL Child Schedules Page _____ of _____

Authorization to Supply Information

I hereby authorize the _____ County Department of Social 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 has provided information to the county department with my written consent, to the following:

The county department is authorized to release information to the following:

**Any child care provider I may choose to use, any employer for whom I work,
and/or any school or training institution I may be attending.**

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

Authorization to Release Information

I authorize the persons, agencies, or institutions entered below to supply information to the County Department of Social 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 work,**
- **any documentation submitted for self-employment,**
- **and/or any school or training institution I may be attending,**
- **any other information that may be pertinent, including housing.**

Signature of Client: _____ Date: _____

IMPORTANT REMINDERS:

You must report any changes in your family's income (or loss of job), address, phone number, family size, change of employment or training status **in writing** as soon as the change occurs, but no later than 30 days.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social 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 Parent 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 upon your re-determination date. Please ask your eligibility worker for details.

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 20 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 20 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. The person(s) reviewing your case are not responsible for the decision or change you disagree with.

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 county staff who are responsible for making the change in your child care subsidies.

After you have completed a county hearing, if you still disagree with the decision, you may appeal the decision to the State by following these steps:

1. Write a letter to: **Division of Administrative Hearings**
633-17th St, 13th Floor
Denver, CO 80202
2. You must get the letter in the mail not later than 15 days after the county hearing decision has been made.
3. In the letter you need to say 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 you desire to help you, or talk to a legal aid office, or ask your County Social Services people to help you.
4. When your letter is received, you will get a letter from the Office of Appeals explaining what will be done and the date for the appeal hearing. It will also explain who can come with you, who can present testimony and other information about the hearing.

You should be aware that the state and county are required to attempt to collect or get repayment of all benefits provided you for which you were not entitled.

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:

The Secretary of Health and Human Services
370 L'Enfant Promenade, S.W.
Washington, DC 20447

You may detach and keep this page for your information.

COUNTY USE ONLY Case Worker Worksheet Case # _____

Name _____

Case Worker Section B: Eligibility and Authorization Reminders - Case Notes

Individual	Eligible?	Authorization?	Provider Info	Parent Fee:	Pending Info Reminders: (may effect eligibility)
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Primary Adult <input type="checkbox"/> Yes <input type="checkbox"/> No Other Adult <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child 1 <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child 2 <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child 3 <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child 4 <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child 5 <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Other <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	Provider #: Provider Name: Provider #: Provider Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount: \$ Reassigned? <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Address Verify <input type="checkbox"/> Contact Info <input type="checkbox"/> DOB Verify <input type="checkbox"/> Citizen Verify <input type="checkbox"/> Immunize Verify <input type="checkbox"/> Paystubs/Other <input type="checkbox"/> Self Emp Expense <input type="checkbox"/> Other Income <input type="checkbox"/> Parent Schedule <input type="checkbox"/> Child Support Ded <input type="checkbox"/> Child Support Enf <input type="checkbox"/> Job Search <input type="checkbox"/> Training Verify <input type="checkbox"/> Disability Verify <input type="checkbox"/> Other
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Other Info to Document in CHATS Case Notes: <input type="checkbox"/> Reasons for actions not explained in other windows <input type="checkbox"/> Verifications Outstanding <input type="checkbox"/> Special Household Circumstances <input type="checkbox"/> How more than one case relates to this case <input type="checkbox"/> Contact names and info <input type="checkbox"/> ANYTHING that will be helpful to another person working/auditing the case!	Cards Issued: <input type="checkbox"/> Yes <input type="checkbox"/> No Cards Notes:
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Re-determination Date/Info:	Wait List Status:	Confidentiality Entered:
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Other Case Notes to Enter:

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

DOES THIS APPLY TO YOU?	What you need to submit	Other Notes You must report any changes in writing as soon as the change occurs, but no later than 30 days	A Checklist for Your Use
YOU OR OTHER ADULTS IN THE HOUSEHOLD ARE WORKING:	All household members' paystubs from the last 3 months and Employer's Name, Address and Phone number.	Records for each job are required, if you (or other household members) have more than one job.	
YOU OR OTHER ADULTS ARE SELF-EMPLOYED:	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 income.	
YOU OR OTHER ADULTS	Provide a letter from your employer	Save your paystubs to submit them when you get them.	

IN THE HOUSEHOLD JUST STARTED YOUR JOB:	indicating what date you started, what your wages are, how many hours/days you work per week, how often you will be paid and the date of your first paycheck.		
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 amount paid, the frequency of payment(s) and the person(s) receiving the payment(s).	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 school which (1) verifies you are enrolled and are making satisfactory progress. (2) identifies the program you are enrolled in, and (3) identifies when you are expected to complete the school program. Attach a school schedule which includes (1) start and end dates of quarter, semester, or session; (2) days /time of class and (3) number of credits.	Not all counties provide child care while attending school or training. Check with your county for the policy.	
YOU HAVE CHOSEN A PROVIDER FOR CHILD(REN) REQUESTING CARE:	Name/Address of Provider Verification of child's identification Verification of child's birthdate Verification of child's citizenship Each child's immunization records Verification of Child Support Received (If applicable)	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 HAS VERIFICATION OF YOUR ADDRESS OF RESIDENCE REPORTED ON YOUR APPLICATION (IN SECTION 1)	Proof of address such as: Rent Receipt /Lease copy Mortgage statement Automobile Registration Utility or other bill Verification from Lease Holder/Renter Verification from Other county office Verification from Other Gov't Agency Verification from School Voter Registration	You must verify your address reported on your application; the county can verify that address is within the county.	
YOUR COUNTY CAN CONTACT YOU WITH AT LEAST ONE CONTACT ENTERED	Home Phone Work Phone Mobile Phone E-mail address Emergency Contact		

You may detach and keep this page for your information.