ROUTT COUNTY
HUMAN SERVICES

P.O. Box 772790
Steamboat Springs, CO 80477
Tel: (970) 870-5533 Fax: (970) 870-5260
www.co.routt.co.us

Dear Parent:

Thank you for your interest in applying for the Colorado Child Care Assistance Program (CCCAP).

Please complete the application and submit it with *all* verifications as soon as possible. Verifications include but are not limited to:

Identification of the Primary Adult Caretaker
Birth Certificate of Child(ren) requesting care
Proof of Current Residence – Lease/mortgage utility bill, etc.
Proof of Income/Employment (if applicable)–last 30 days of paystubs, self-employment profit and loss or ledger

Once received, your application will be reviewed and you will be contacted regarding your eligibility.

The Child Care Network has a list of all licensed centers and homes in Routt County.
970-879-7330 *or* www.familydevelopmentcenter.org/childcare

Please let us know if you have any questions.

Sincerely,

Fran Snider/Viviana Loya
CCCAP Program Managers
vloya@co.routt.co.us
fsnider@co.routt.co.us
970-870-5280

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

Application for Colorado Child Care Assistance Program (CCCAP)

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

Section 1: Household Information

Today's Date: ____/____/_____	If you are not the parent of child(ren) for whom you are applying, are you the Primary Adult Caretaker? Are there other Adult Caretaker(s) in the household?	☐ Yes ☐ No ☐ Yes ☐ No

Primary Adult Caretaker's Last Name:	Primary Adult Caretaker's First Name:	Middle Initial:

Do any of the following apply to your current living situation? **Please complete if applicable.**	☐ Living in hotel or motel	☐Living in campground	☐ Living in shelter	☐ Living in substandard housing such as car, park, etc.
	☐ Other irregular living situation (please explain)		Date living situation began: ____/____/_____ Anticipated end date: ____/____/_____	

Residence Address:			Mailing Address: ☐ Same as residence?		
City:	State:	Zip:	City:	State:	Zip:
County:			Primary language spoken in the home:		

Contact Information: *Complete at least one*	Primary Phone: ( ) Type:☐ Home ☐Cell ☐ Voice Msg.☐ Work	Secondary Phone: ( ) Type:☐ Home ☐Cell ☐ Voice Msg.☐ Work	Email Address:

Do you or anyone else in your household receive benefits from or participate in any of the following programs?		**If no, would you like to receive more information?**
Colorado Works/TANF cash assistance	☐ Yes ☐ No	☐ Yes ☐ No
Head Start/Early Head Start	☐ Yes ☐ No	☐ Yes ☐ No
Low-Income Energy Assistance (LEAP)	☐ Yes ☐ No	☐ Yes ☐ No
Food Assistance (SNAP)	☐ Yes ☐ No	☐ Yes ☐ No
Women, Infants and Children (WIC) Program	☐ Yes ☐ No	☐ Yes ☐ No
Child and Adult Care Food Program	☐ Yes ☐ No	☐ Yes ☐ No
Medicaid/CHP+ Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Housing voucher or cash assistance	☐ Yes ☐ No	☐ Yes ☐ No
Refugee Medical Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Individuals with Disabilities Education (IDEA) Services Part B (3-5yrs)	☐ Yes ☐ No	☐ Yes ☐ No
Individuals with Disabilities Education (IDEA) Services Part C (0-3yrs)	☐ Yes ☐ No	☐ Yes ☐ No
Old Age Pension	☐ Yes ☐ No	☐ Yes ☐ No
Other (please explain):_____	☐ Yes ☐ No	☐ Yes ☐ No

Section 2: Primary Caretaker Information

Last Name:	First Name:	Middle Initial:
Social Security Number: _____-____-_____ (Optional)	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: ☐ Male ☐Female

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

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

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

ACTIVITY: Check all that apply to this individual

☐ Employed	☐ Self-Employed	☐ Job Search	☐ Post-Secondary School
☐ Training/Education	☐ English as a second language	☐ GED/High School Equivalency	☐ Middle / Jr. High
☐ Disabled	☐ National Guard	☐ Military Reserves	☐ Active Military (serving full time)

Section 3: Additional Adult Caretaker/Spouse

An additional adult caretaker in the household is one who provides financial assistance and helps care for your child

Last Name:	First Name:	Middle Initial:
Social Security Number: _____-____-_____ (Optional)	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: ☐ Male ☐Female

Relationship to the Primary Adult Caretaker:

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

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

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

ACTIVITY: Check all that apply to this individual

☐ Employed	☐ Self-Employed	☐ Job Search	☐ Post-Secondary School
☐ Training/Education	☐ English as a second language	☐ GED/High School Equivalency	☐ Middle / Jr. High
☐ Disabled	☐ National Guard	☐ Military Reserves	☐ Active Military (serving full time)

Section 4: Child Information Complete this section for <u>each</u> child in your home

Last Name:	First Name:	Middle Initial:

Social Security Number (Optional):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to the Primary Adult Caretaker:
_____-____-_____	____/____/_____	☐ Male ☐ Female	

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

Is this a child who is part of a Joint Custody agreement or another case?	☐ Yes ☐ No	Are you requesting care for this child?	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ No		

Immunization status: ☐ Yes, Immunized ☐ No, In Process ☐ No, Religious Exemption ☐ No, Medical Exemption			
Is this child enrolled in a Head Start/Early Head Start Program? ☐ Yes ☐ No If yes, what is their enrollment start date and end date? Start:___/____/_____ End: ___/____/_____		Does this child have a disability or have additional care needs?	☐ Yes ☐ No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	☐Yes ☐ No
If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

Section 4 Cont'd Complete this section for <u>each</u> child in your home

Last Name:	First Name:	Middle Initial:

Social Security Number (Optional):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to the Primary Adult Caretaker:
_____-____-_____	____/____/_____	☐ Male ☐ Female	

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

Is this a child who is part of a Joint Custody agreement or another case?	☐ Yes ☐ No	Are you requesting care for this child?	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ No		

Immunization status: ☐ Yes, Immunized ☐ No, In Process ☐ No, Religious Exemption ☐ No, Medical Exemption			
Is this child enrolled in a Head Start/Early Head Start Program? ☐ Yes ☐ No If yes, what is their enrollment start date and end date? Start:___/____/_____ End: ___/____/_____		Does this child have a disability or have additional care needs?	☐ Yes ☐ No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	☐Yes ☐ No
If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

Section 4 Cont'd Complete this section for <u>each</u> child in your home

Last Name:	First Name:	Middle Initial:

Social Security Number (Optional):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to the Primary Adult Caretaker:
_____-____-_____	____/____/_____	☐ Male ☐Female	

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

Is this a child who is part of a Joint Custody agreement or another case?	☐ Yes ☐ No	Are you requesting care for this child?	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ No		

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

Is this child enrolled in a Head Start/Early Head Start Program? ☐ Yes ☐ No If yes, what is their enrollment start date and end date? Start:___/____/_____ End: ___/____/_____	Does this child have a disability or have additional care needs?	☐ Yes ☐ No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	☐Yes ☐ No
If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

Section 4 Cont'd Complete this section for <u>each</u> child in your home

Last Name:	First Name:	Middle Initial:

Social Security Number (Optional):	Date of Birth:	Gender:	Relationship to the Primary Adult Caretaker:
_____-____-_____	____/____/_____	☐ Male ☐Female	

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

Is this a child who is part of a Joint Custody agreement or another case?	☐ Yes ☐ No	Are you requesting care for this child?	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ No		

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

Is this child enrolled in a Head Start/Early Head Start Program? ☐ Yes ☐ No If yes, what is their enrollment start date and end date? Start:___/____/_____ End: ___/____/_____	Does this child have a disability or have additional care needs?	☐ Yes ☐ No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	☐Yes ☐ No
If your child is <u>not</u> receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN

Page _____of _____

Section 5: Primary Caretaker Work/Self-Employment Income

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

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

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

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

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

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

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

Section 7: Court Ordered Child Support Paid Out

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

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

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

Section 8: Child Support Ordered and/or Received

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

Child Name(s)	Is child support ordered?	Is child support received?	Amount of Child Support Paid	How often paid	Name of non-custodial parent
	☐ Yes ☐ No	☐ Yes ☐ No			
	☐ Yes ☐ No	☐ Yes ☐ No			

Section 9: Other Income Complete information in Section 9 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?
Other Income Types: Refugee Cash Assistance Social Security (Survivor's, Disability, Retirement) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Railroad Retirement Benefits Veteran's Benefits Supplemental Security Income (SSI) TANF/Colorado Works Cash Assistance Other (Describe under Individual)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	☐ Yes ☐ No If yes, list amount: $_____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	☐ Yes ☐ No If yes, list amount: $_____
Individual Name:	Effective Begin Date:	Effective End Date:	Docket/Court Case # (if applicable)
	Income Source (from below):	Gross Amount	How Often is this income received?
Other Income Types: Refugee Cash Assistance Social Security (Survivor's, Disability, Retirement) Unemployment Compensation Retirement or Pension (Not SS) Insurance/Lawsuit Settlement Proceeds Interest on savings, CDs, IRAs, 401Ks Railroad Retirement Benefits Veteran's Benefits Supplemental Security Income (SSI) TANF/Colorado Works Cash Assistance Other (Describe under Individual)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Annuity Cash Contributions Alimony/Maintenance Lease bonus/royalties Military Allotment Strike Benefits Trust Income AmeriCorps Income Worker's Compensation Old Age Pension	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Assets: Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments)	☐ Yes ☐ No If yes, list amount: $_____	Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	☐ Yes ☐ No If yes, list amount: $_____

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS

Page _____ of _____

Section 10: Adult Caretaker Training/Education/Teen Education Detail

Are you or another household member participating in a training/education activity? ☐ **Yes** ☐ **No**

If YES, complete the following: **(VERIFICATION IS REQUIRED)**

Name:		Effective Begin Date:	Effective End Date:
Number of Credits:	Training Institution:	Type of Training: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐Post-Secondary Education ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐Certificate Program	Anticipated Completion Date:
Name:		Effective Begin Date:	Effective End Date:
Number of Credits:	Training Institution:	Type of Training: ☐Adult Basic Education ☐English As A Second Language (ESL) ☐Post-Secondary Education ☐GED/High School Equivalency ☐High School/Jr. High ☐Job Skills Training ☐Certificate Program	Anticipated Completion Date:

Section 11: Adult Caretaker Disability Detail

Are you or another Adult Caretaker disabled? ☐ **Yes** ☐ **No**

If YES, complete the following: **(VERIFICATION IS REQUIRED)**

Name:		Disability Begin Date:	Disability End Date:
Disability Type: ☐ Permanent ☐Temporary	Is this Individual able to take care of the child(ren)? ☐ Yes ☐ No	Physician Review Due Date, if applicable:	
Name:		Disability Begin Date:	Disability End Date:
Disability Type: ☐ Permanent ☐Temporary	Is this Individual able to take care of the child(ren)? ☐ Yes ☐ No	Physician Review Due Date, if applicable:	

Section 12: Adult Caretaker(s) Employment/Training/School/Job Search Schedule

Please fill in your expected schedule. If there are two adult caretakers, fill in schedules for both. If you have more than one job please list your work schedule for both jobs. (VERIFICATION IS REQUIRED.)

Example	Mon. 8:00a - 5:00p	Tues. 8:00a - 5:00p	Weds. 8:00a - 5:00p	Thurs. 8:00a - 3:00p	Fri. 8:00a - 5:00p	Sat. 8:00a-12:00p	Sun. 8:00a - 5:00p
MY SCHEDULE							
Work/Job Search							
Training/School							
2ND ADULT CARETAKER	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							

Section 13: Children's Schedule for children needing care

(Do not complete for children who do not need care.)

Child Name	Child In School	Grade and School Of Attendance	Child's Schedule: Please indicate times you plan to have your child in care each day for each provider used Provider License #, Name, Address and Phone # (If known)	Mon. *8:00a – 5:00p*	Tues. *8:00a – 5:00p*	Wed. *8:00a – 5:00p*	Thurs. *8:00a – 5:00p*	Fri. *8:00a – 5:00p*	Sat. *8:00a – 5:00p*	Sun. *8:00a – 5:00p*
	☐Yes ☐No									
	☐Yes ☐No									
	☐Yes ☐No									
	☐Yes ☐No									

Authorization to Supply Information

Authorization to Supply Information

I hereby authorize the County Department of Social/Human Services, in the course of administering the social services program, to supply information to any of the entities listed below. I release the county department from any and all liability for supplying such information.

- Any child care provider I may choose to use,
- any employer for whom I currently work or have worked,
- any school or training institution I may be attending
- any housing authority
- and/or any other information that may be pertinent to my application for or receipt of public assistance programs including Head Start and Early Head Start.

Authorization to Release Information

I authorize the persons, agencies, or institutions entered below to supply information to the County Department of Social/Human Services concerning my application for or receipt of social services. I also allow inspection and reproduction of records in their possession pertaining to me by any authorized representative of the county department. I release the person, agency, or institution from any and all liability for supplying such information.

- Any child care provider I may choose to use,
- any employer for whom I currently work or have worked,
- any documentation submitted for self-employment,
- any school or training institution I may be attending,
- any housing authority,
- and/or any other information that may be pertinent to my application for or receipt of public assistance programs including Head Start and Early Head Start.

☒Signature of Client: _____ Date: _____

☒Signature of Spouse and/or Other Adult Caretaker:_____Date:_____

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 www.coloradoofficeofearlychildhood.com.

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. To provide my child care worker with a copy of my un-expired picture ID that has been taken in the past ten (10) years issued by a school or U.S. federal or state governmental agency if I am declaring the identity of my child(ren) due to the child(ren) not having identification as part of the application or at re-determination if it was not previously received by my child care worker.

4. 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.

5. To notify my child care worker prior to changing child care providers otherwise the county may not pay for my child care.

6. To cooperate with the Child Support Services office for any child that is receiving care and has an absent parent if my county requires cooperation with Child Support Services.

7. 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.

8. 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.

9. To pay the parent fee listed on my child care authorization notice to my child care provider in the month that care is received.

10. If my CCCAP case closes and less than thirty (30) days have passed from 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 adult caretaker on 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 noticed 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 another caretaker on 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.

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

☒ Signature of Primary Adult Caretaker: _____ Date: _____

☒ Signature of Other Adult Caretaker: _____ Date: _____

Thank you for completing this form. If you have any questions call the Child Care Assistance Program (CCAP) at your County Department of Social/Human Services.

RIGHT OF APPEAL AND FAIR HEARING

If you disagree with any action taken in regards to child care benefits, you have a right to appeal.

- If your child care benefits are denied, you must call your child care assistance worker within fifteen (15) days of the date of that denial to say that you want to appeal.
- If your child care benefits are changed, you must call your child care assistance worker within fifteen (15) days of the date of the notice of the change to say that you want to appeal.
- If your child care benefits are terminated, you must call your child care assistance worker before the effective date of the termination to say that you want to appeal.

A hearing will be scheduled by the county department. At the hearing, you will be given an opportunity to present your case. If you appeal the decision or change, the person who officiates at the hearing shall not be the originator of the change or decision.

Before you decide to request a county hearing, we encourage you to talk with your county department child care worker first, and then the worker's supervisor. Often your questions and concerns can be settled by talking to the county staff responsible for making the change in your child care subsidy.

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

1. Write a letter to:

   Office of Administrative Courts
   1525 Sherman Street
   4th Floor
   Denver, CO 80203

2. You must appeal the county decision within 15 days of the mail date on the Notice of County Hearing Decision.

3. In the letter you need to state that you want to appeal the county hearing decision and why you want to appeal the decision. If you need help doing this you can ask anyone to help you, or talk to a legal aid office, or ask your County Social/Human Services representative to help you.

4. The Office of Administrative Courts will schedule a date for the appeal hearing if it is determined the request was filed timely. You will receive a letter from the Office of Administrative Courts explaining the next steps, who may come with you, who may present testimony and other information about the hearing.

You should be aware that the state and county are required to attempt to collect all benefits provided for which you were not eligible.

Discrimination

If you believe that you have been discriminated against because of race, color, sex, age, religion, political beliefs, national origin, or handicap, you have a right to file a complaint with:

Office for Civil Rights

U.S. Department of Health & Human Services

1961 Stout Street – Room 1426

Denver, Colorado 80294

(303) 844-2024 or (303) 844-3439 (TDD)

Keep this page for your reference

ROUTT COUNTY
HUMAN SERVICES

P.O. Box 772790
Steamboat Springs, CO 80477
Tel: (970) 870-5533 Fax: (970) 870-5260
www.co.routt.co.us

COLORADO CHILDCARE ASSISTANCE PROGRAM (CCCAP) APPLICANTS:

As a condition of eligibility for the CCCAP Program, Routt County requires that, if both parents are not in the home, then you must cooperate with the Child Support Services (CSS) Office in establishing a child support order for the non-custodial parent of the child(ren) for whom you are applying. If you fail to cooperate with the CSS Office; you will lose your Childcare Assistance.

Cooperating means naming the parent of any child(ren) for whom you are applying for CCCAP, and providing any information you have regarding the parent. **Attached is a CSS application you will need to complete only if the non-custodial parent is not in the home.**

You may have good cause for refusing to cooperate with the CSS Office, if you meet the criteria listed below. It is your responsibility to provide the county department with evidence to prove that you have good cause for not cooperating within 20 days from claiming good cause. If needed, you may request additional time from the county department. The situations in which good cause for not cooperating may exist include:

Cooperation may result in serious physical or emotional harm to the child(ren), to you, or both. Examples of evidence include court, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the alleged non-custodial parent might inflict physical or emotional harm on you or the child(ren). Also past or current medical records which indicate potential harm to you, the child(ren), or both, or sworn statements from persons who have knowledge of the basis of your good cause claim.

The child was born after forcible rape or incest. Evidence includes medical or law enforcement records indicating incest or forcible rape occurred, or sworn statements from persons who have knowledge of the basis of your good cause claim.

The child is in the process of being adopted. Evidence includes court documents and/or written statements from the public or private agency that is handling the adoption.

The county department will consider the evidence and decide if you have good cause for not cooperating.

Do you wish to request good cause for refusing to cooperate with the Child Support Services Office?
YES____ NO____

Printed Name:_____ Date:_____

Signature:_____

COLORADO
Office of Economic Security
Division of Child Support Services

For Office Use Only:
Date Sent _____/ _____/
Date Received _____/ _____/
Fee paid by: CP NCP County CSS

APPLICATION FOR CHILD SUPPORT SERVICES (CSS)

ROUTT _____ County

Important Security Information

We share your address and other identifying information with other state and federal agencies only for child support reasons. The information you provide may become available to the other parent. Contact us immediately if the following conditions exist:

- **Your case information should not be given out because of family violence.**
  - Confidentiality laws protect all information provided to CSS. CSS offices throughout the United States and some countries have access to this information through State and Federal Child Support Case Registries. If family/domestic violence is an issue, you must alert CSS to further safeguard this information.

- **Going through the child support process poses a threat to you or your child (ren).**
  - If you have concerns about you or your child (ren)'s safety, there are some protections available in the child support process. Please let your county worker know about your concerns. If you have concerns for you or your child (ren)'s safety, please complete the last page of this application: *Request for Nondisclosure of Personal Information*.

GETTING STARTED

A $20.00 non-refundable application fee (check, money order or exact cash if applying in person) is required to process this application. Please do not mail cash. **If you have applied for or are receiving TANF this fee may not be required.**

WHAT WE NEED FROM YOU:

To start the process, please supply the following legal documents:

1. One (1) application for each non-custodial/custodial parent
2. Copy of a state-issued birth certificate and social security card for each child
3. Copy of personal identification (i.e. driver's license)
4. A photo of the other parent, if available; it will be returned to you
5. Verification of your income (i.e. pay stubs, tax returns)
6. Copy of Marriage Certificate (if not available, supply date of marriage and/or other evidence of marital status)

7. Copy of Court Order(s) signed by a judge or magistrate (if not available supply date, county, state of filing and court case number):
    - Petition and/or Divorce Decree and/or Separation Agreement
    - Paternity Orders
    - Certified Copy of Child and/or Spousal Support Order
    - All modified orders
    - Allocation of Parental Responsibility Orders
    - Probate Orders
    - Dependency and Neglect Orders
    - Adoption Orders
    - Orders Terminating Parental Rights
8. Complete payment records of all support paid to the custodial party directly, through court or a state disbursement unit
9. Are you related to anyone working in the county Department of Human Services offices? No:___ Yes:____ If yes, who:_____

Note: Your application may be delayed if you do not provide the necessary documentation.

SERVICES PROVIDED BY CSS

CSS is authorized by law to provide the following services:

1. Establish child/medical support orders and paternity
2. Modify child/medical support orders
3. Enforce child/medical support orders, including spousal maintenance when combined with child support
4. Process payments through the Family Support Registry (FSR); once an FSR account number is assigned to you, you will be able to register on the CSS website (www.childsupport.state.co.us) to view your account information online
5. Collect past due child support from the non-custodial parent's federal and state tax refunds and lottery winnings
6. Collect past due child support from the non-custodial parent through other enforcement remedies
7. Ask another state's child support agency to establish, modify or enforce an order on our behalf.

CSS has authority to hold an IRS joint tax refund prior to release of funds for up to six months. Interest will not be paid on funds that are held.

HOW WE WORK TOGETHER

Please read and initial each of the following statements. By *initialing each statement, you understand and agree:*

_____CSS represents the People of the State of Colorado. No attorney-client relationship or privilege exists between either party or the CSS staff.

_____CSS does not handle parental responsibility (custody), parenting time (visitation) or property settlement. Your county may have additional resources to address those issues. Please ask your county worker.

_____CSS will not accept the Application for Services if all the children associated with the applicant are emancipated.

_____CSS will not enforce maintenance once current child support ends.

_____CSS determines the appropriate actions to be used when providing services.

_____If there is a change that could cause an adjustment to the amount of the order (e.g. financial, medical, etc.), a modification may be initiated by the department or by any one of the parties.

_____A written request from the applicant to stop CSS services may be made. However, if you are receiving TANF or assigned arrears are owed, the case may remain open. CSS may also close your case by using criteria established by current state and federal regulations (e.g. not being able to locate you, you do not supply a forwarding address, you do not provide required documents to take the next step to work your case, etc.).

_____CSS will provide to the applicant a yearly statement that summarizes the amount of child support that has been collected. I have an opportunity to receive the information through electronic means, if I choose to do so.

_____Each individual county determines optional services. Inquire about services available in the county of application.

YOUR RESPONSIBILITIES

You are the best source of information regarding the other party. The information you provide may help in the progress of your case. There may be a delay in the progress of your case due to lack of information and/or involvement with another state.

You are required to cooperate with CSS in the processing of your case. Failure to do so may result in case closure.

If you are a caretaker/relative (e.g. grandparent, aunt, uncle, adult sibling, stepparent, etc.) you

are required to open a child support case against both biological parents. CSS will not close only one of the two cases against the biological parents at your request.

You may be required to complete and sign an affidavit agreeing to the amount of child support arrears owed (if there is a current child support order).

If you have special needs or need special accommodations under the Americans with Disabilities Act, you must contact the county of application.

You must notify the CSS office in writing if any of the following changes occur. Failure to do so may affect your child support payments or medical support payments.

1. Change to your legal name, residence/mailing address, telephone or contact numbers, place of employment, or health insurance or if you know of changes about the other party.
2. If child support payments are made directly to the custodial party instead of through the FSR.
3. If a child no longer lives with the custodial party due to emancipation or child goes to live with the other parent or caretaker.
4. If parenting time (visitation) changes for longer than one month.
5. If you retain a private attorney or private collection agency regarding child support, parenting time (visitation) or parental responsibility (custody).
6. If an action has been filed with a court that CSS was not involved with (e.g. separation, divorce, parental responsibility, etc.).

If a payment is sent in error or is unfunded (i.e. bounced check), it is your responsibility to pay back the unfunded amount. You may repay in full or CSS will deduct 10% or $10.00 (whichever is greater) from each payment received until the balance is paid in full. The non-custodial parent will still owe the unfunded amount.

Once a Family Support Registry (FSR) account number has been assigned, sending or receiving direct payment may result in case closure. The FSR is the central payment processing center for Colorado.

The provision of your Social Security Number (SSN) is mandatory (§42 U.S.C. 666(a) (13)). However, if you do not have a SSN, your application for services will not be denied. SSNs are used by the CSS Program to locate individuals to establish paternity or support obligations, modify and enforce support obligations and to distribute child support payments.

Please note:

- Arrears owed to the custodial party are before TANF arrears are paid to the State of Colorado, unless there is a federal tax intercept.
- Federal law requires CSS to withhold $35.00 one time each year from the child support collected on a non-public assistance case, if over $550.00 is collected during the year.

Are you applying for help with any of the following issues (please check all that apply):

Modify your child support amount_____ Change parent with physical care_____

DNA testing for multiple alleged fathers_____ Collection of alimony/maintenance_____

Print Legal Name:_____

Signature of applicant: _____ Date:_____

For more child support information and additional forms you may visit our website at:
www.childsupport.state.co.us

APPLICANT INFORMATION

Relationship to the child(ren):	Mother	Father	Other, explain		
Legal Name:	Last	First	Middle	Maiden/Other	
Social Security # or ITIN #:		Date of Birth:	Gender:		
Place of Birth:	**City**	**State**	**County**		
Residence Address	**Street**	**Apt/unit**	**City**	**State**	**Zip**
Mailing Address (if different)	**Street**	**Apt/unit**	**City**	**State**	**Zip**
Contact Numbers	**Home**	**Cell**	**Work**	**Email address:** Would you like to opt into receive text messages concerning your case?	
Emergency contact (if you can't be reached)					
Address	Street	**Apt/unit**	**City**	**State**	**Zip**
Employer and or Union					
Address	**Street**	**City**	**State**	**Zip**	
Occupation/Trade					
Is it ok to contact you at work? Yes or No	Work Schedule:				
What was the situation (Leading up to custody)?					
Is there an attorney involved in this case?	Yes	No			
If yes, Attorney's Information: Name Phone number:	Address	City	State	Zip	

Have the children ever received public assistance?		Yes	No
Yes: what type was received?	TANF	Medicaid	Foster Care
What County/State?		Begin Date:	End Date:
If you are the mother, are you pregnant now?		If yes, what is the due date?	
If yes, Who is the father of the expected child?			

OTHER PARENT INFORMATION

Relationship to the child(ren): Mother Father Possible Father (paternity NOT established) **Is Parent Deceased?**					
Legal Name:	Last	First	Middle	Maiden/Other	
Social Security # or ITIN #:		Date of Birth		Gender	
Place of Birth:	**City**	**State**		**County**	
Current or last known Address	**Street**	**Apt/unit**	**City**	**State**	**Zip**
Mailing Address (if different)	**Street**	**Apt/unit**	**City**	**State**	**Zip**
Contact Numbers	**Home**	**Work**	**Cell**	**Email address**	
Emergency contact (if other parent can't be reached)		**Name**			
Address	**Street**	**Apt/unit**	**City**	**State**	**Zip**
Current or last known employer and or Union					
Address	**Street**	**City**		**State**	**Zip**

Occupation/Trade				
Physical Description: Height: Identifying Marks (scars, tattoos, piercings)		Weight:	Hair Color:	Eye Color:
Race: Caucasian	African American	Hispanic	Asian	Other
In Prison: Currently or previously		Which facility: DOC #		Date of release:
In the military:		Branch of Service		
Are they disabled?		If yes, do they receive SSI?		
List any assets they may have: i.e. Real estate, bank accounts, license to work a profession(plumber, electrician)				
List any vehicles(model, make, year, color)		Driver's License Number:		
Other parent's mother's information	Name/Maiden Name	Address	Phone	
Other Parent's Father's information	Name	Address	Phone	
List any other biological Child(ren)				
Child(ren)'s other biological parent:				
Is there any other information that will help us locate the other parent?				
Does the other parent have an attorney: Yes No	If yes, Name:	Address	Phone #:	

CHILD (REN)'S INFORMATION

	Child 1	Child 2	Child 3
Legal Name			
Gender (M or F)			
Date of Birth			
Social Security Number			
City & State of Birth			
State or County of Conception			
Who are listed as the Parents on the Birth Certificate?			
Child Support Order #, County and State			
	Child 4	**Child 5**	**Child 6**
Legal Name			
Gender (M or F)			
Date of Birth			
Social Security Number			
City & State of Birth			
State or County of Conception			
Who are listed as the Parents on the Birth Certificate?			
Child Support Order #, County and State			

PARENT OF THE APPLICATION, RELATIONSHIP STATUS

Were the Parents of the child (ren) ever married to one another?	If yes, Date and State of Marriage, Common Law or Civil Union.	
Date Separated:	Date Divorced:	In what city, county, state?
Date of last contact with the other parent:		

If Paternity has been established, How?	Genetic Testing	Acknowledgement of Paternity	Court Order
Did this person ever live with the child (ren) in the State of Colorado?		If yes, When and Where?	

MEDICAL INSURANCE INFORMATION

A copy of the benefit card used to process medical claims MUST be provided.

Is your child (ren) on Medicaid?	Yes	No
Does your child (ren) have health insurance coverage other than Medicaid?	Yes	No
If yes, name the children covered by the other insurance:		

Other insurance company's information:

Insurance Company Name:	
Address:	Policy Number:
Phone number:	Group Number/Member ID:
Date Insurance began:	Type of coverage: Medical Dental Vision Other

Who provides other insurance coverage?

Name	Social Security Number
Relation to the covered child(ren)	
Address:	Phone number:

Please complete only if you have concerns for you or your child (ren)'s safety.

Request for Nondisclosure of Personal Information

If you have safety concerns for you or your family because your personal information including address, date of birth or social security number is shared with a court and is available to the other party, or you have had domestic violence issue and/or a restraining order, you may request an Affidavit of Nondisclosure of Personal Information (NDI).

You will be required to provide an alternate address at which you can receive mail. This address must be in Colorado. You must keep the county child support enforcement office informed of any change to this address. This address will be provided to the court and the other party.

Requesting NDI is a very serious matter and the Division of Child Support Services strongly encourages anyone experiencing domestic violence issues to contact the State of Colorado's Address Confidentiality Program. Their web site is www.acp.state.co.us for more information. This program provides an alternate address for qualified recipients. The address is located in Denver, Colorado and is a legal address at which service of process can be accomplished.

If you wish to request an Affidavit of Nondisclosure, complete the following information which is needed to prepare an affidavit. When your case has been initiated, you will receive an affidavit in the mail which you need to complete and return to the Child Support Enforcement Unit immediately. This only keeps information out of the court file, nothing else. If the other party knows where you live, this will NOT help you in keeping your current address confidential.

A request for nondisclosure of personal information on court documents is **NOT A PROTECTIVE ORDER.**

I _____, understand that I must provide an alternate address where I am willing to accept service of process and can receive mail. This address will be provided to the court and the other party. The address must be in Colorado. All legal documents will be sent to this alternative address.

Alternate Mailing Address: _____

Care of- if applicable_____

City, State and Zip Code: _____

Signed: _____

Date:_____