



Workforce Development *is* Economic Development

512 29 ½ Road

Grand Junction, CO 81501

970-248-0871

Fax 970-255-3613

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Dear CCCAP applicant,

Please complete the application and **sign the signature line on page 17** of the application. **Interviews will be conducted via phone, unless an in person interview is requested.** Please list the best day and time to call you for the interview. We will schedule your phone interview once all your verifications have been received.

**Please use this as a checklist of verifications we will need to process your application:**

- Verification of your address (such as a copy of your lease, a current bill, vehicle or voter registration, tax form, etc.)
- Verification of other income, such as child support, Veteran's Benefits, Social Security, unemployment, etc.
- If you do not have a child support case, you can file a new application online at <https://childsupport.state.co.us/> or via paper applications available at the Workforce Center.
- If you share custody of your child with the other parent, please submit the parenting schedule form attached, or bring a copy of a court order.
- Daycare information (name, address, phone number) and time of care schedule for each child. If you need help to find a provider please visit BridgeCare at <https://childcare.mesacountypcf.org>.
- Verifications for each parents' activities (employment, self-employment or school)
  - If you are employed, we will need:***  
The last 30 days of paystubs, OR  
For new job, an employment verification signed by your employer (form attached)
  - If you are self-employed, we will need:***  
Monthly ledgers showing income and expenses for the last 30 days.
  - If you are a student, we will need:***  
A copy of your concise school schedule.

Please note that this list may not include all verifications needed. Every case is different, and extra documentation may be requested by your eligibility worker under certain circumstances. ***We cannot backdate care, so please submit all verifications with the application for quicker processing.***

*Please call Carlie Reed at 970-248-2735 with any questions.*



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**Federal Poverty Limit in Mesa County for Child Care  
Oct 1, 2024 – September 30, 2025**

<b>Family Size</b>	<b>185% Federal Poverty Limit for Mesa County Child Care Intake</b>
<b>2</b>	<b>\$3,151</b>
<b>3</b>	<b>\$3,980</b>
<b>4</b>	<b>\$4,810</b>
<b>5</b>	<b>\$5,639</b>
<b>6</b>	<b>\$6,468</b>
<b>7</b>	<b>\$7,298</b>
<b>8</b>	<b>\$8,127</b>
<b>9</b>	<b>\$8,957</b>

For CCCAP Staff to Complete:

Application Received Date:

Pre-Eligibility: Yes  No

Determined by: Provider  County

Case Number:

## Application for Colorado Child Care Assistance Program (CCCAP)

### Definitions:

- **You** = The parent or primary guardian completing the application.
- **Primary Guardian** = An adult, not the parent, legally responsible for caring for a child.
- **Teen Parents** = Parent under twenty-one (21) years of age who has physical custody of their child(ren) for the period that care is requested and is in an eligible activity such as attending junior high/middle school, high school, GED program, vocational/technical training activity, employment, self-employment, or job search.
- **Additional Guardian/Spouse** = A person who lives in your house that cares for your children and/or provides financial assistance and support. This is a person who is assuming the parent obligations for a minor, including protecting their rights and/or a person who is standing in the role of the parent of a minor without having gone through the formal adoption process.

### Instructions:

- **This application must be submitted by the parent or primary guardian of the children needing child care.**
- **Completing this application does not guarantee child care assistance.**
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please address each section and 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.

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

### Section 1: Your Household Information (REQUIRED)

Today's Date: ____/____/____	Are you the <b>parent</b> or <b>primary guardian</b> of the child(ren) for whom you are applying? <input type="checkbox"/> Parent <input type="checkbox"/> Primary Guardian	Is there an <b>Additional Guardian/Spouse</b> in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your Last Name:	Your First Name:	Your Middle Initial:

### Do any of the following describe where you live?

<input type="checkbox"/> Living in hotel or motel	<input type="checkbox"/> Living in campground	<input type="checkbox"/> Living in shelter	<input type="checkbox"/> Living in someone else's home due to housing loss, economic struggles, etc.	<input type="checkbox"/> Living in substandard housing such as car, park, abandoned building, etc.	<input type="checkbox"/> Other temporary living situation (please explain):	<input type="checkbox"/> None apply
Date living situation began: ____/1____/1____						
Anticipated end date (if known): ____/____/____						

Your Address:			Mailing Address: <input type="checkbox"/> Same as your address?		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Contact Information: <i>Complete at least one</i>	Your Email Address ( <b>required</b> ):		Primary Phone: ( ) Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	Secondary Phone: ( ) Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Voice Msg. <input type="checkbox"/> Work	
Preferred Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail					
Preferred language spoken in the home:					

<b>There are other programs that can benefit you and your family...</b>	
So that we can connect you to those programs, please select one of the three options below for each program: I participate; I'd like to learn more; or I am not interested. <i>*If you select that you would like to learn more, you will be connected to those programs to complete their referral or application processes to see if you qualify.</i>	
<b>Head Start/Early Head Start Education Programs:</b> free, quality education for children 0 to 5 years old <i>(not available in all communities).</i>	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Early Intervention Colorado:</b> developmental supports available at no cost for children birth up to 3 years old	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more because I am concerned about my birth up to 3-year-old child's development. <input type="checkbox"/> I'm not interested.
<b>Preschool Special Education:</b> education supports available at no cost for 3- to 5-year-olds	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more because I am concerned about my 3- to 5-year-old child's development. <input type="checkbox"/> I'm not interested.
<b>Colorado Works/Temporary Assistance for Needy Families (TANF) Cash Assistance:</b> cash assistance for those who qualify	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Food Assistance (SNAP):</b> assistance buying food	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Women, Infants and Children (WIC) Food and Nutrition Program:</b> food, nutrition, and breastfeeding supports for you and your 0-5-year-old child(ren)	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Medicaid/CHP+ Health Insurance Assistance:</b> health coverage for those who qualify.	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Housing Choice Voucher or cash assistance:</b> assistance paying my rent or utilities	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Low-Income Energy Assistance (LEAP):</b> assistance paying my heating bill	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
<b>Refugee Medical Assistance:</b> medical assistance for refugees	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.

<b>Child Support Services</b> Services that make sure that children receive regular financial support from both parents.	<input type="checkbox"/> I participate. <input type="checkbox"/> I'd like to learn more. <input type="checkbox"/> I'm not interested.
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**Section 2: Your Information (REQUIRED unless otherwise indicated)**

Your Social Security Number: _____ - ____ - _____ <b>(optional)</b>	Your Date of Birth (MM/DD/YYYY): ____ / ____ / ____	Your Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Race <b>(optional, mark all that apply):</b>	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Other

Highest Grade Completed:	<input type="checkbox"/> Less Than High School/High School Equivalency	<input type="checkbox"/> High School/High School Equivalency	<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Bachelor's Degree
	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Ph.D./Doctorate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____

Marital Status:	<input type="checkbox"/> Married, Living w/Spouse	<input type="checkbox"/> Married, Not Living w/Spouse (voluntarily)	<input type="checkbox"/> Married, Not Living w/Spouse (involuntarily)	
	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single – Never Married	<input type="checkbox"/> Widowed/Widower	<input type="checkbox"/> Divorced

**QUALIFYING ACTIVITY: Check all that apply to you**

<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Job Search	<input type="checkbox"/> Post-Secondary School Student
<input type="checkbox"/> Training/Education	<input type="checkbox"/> English as a Second Language Student	<input type="checkbox"/> GED/High School Equivalency Student	<input type="checkbox"/> Middle / Jr. High Student
<input type="checkbox"/> Disabled	<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	<input type="checkbox"/> Active Military (serving full time)

**Section 3: Additional Guardian/Spouse's Information**

**REQUIRED: Do you have an additional guardian/spouse?**       Yes       No

**If YES, you're required to complete the following table unless otherwise indicated. If NO, skip to Section 4.**

Guardian/Spouse Last Name:	Guardian/Spouse First Name:	Guardian/Spouse Middle Initial:
Social Security Number (optional): ____ - ____ - _____	Date of Birth (MM/DD/YYYY): ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to You:		

\*Guardian/Spouse Email Address (optional):

Race <b>(optional, mark all that apply):</b>	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Other

Highest Grade Completed:	<input type="checkbox"/> Less Than High School/High School Equivalency	<input type="checkbox"/> High School/High School Equivalency	<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Bachelor's Degree
	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Ph.D./Doctorate	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____

Marital Status:	<input type="checkbox"/> Married, Living w/Spouse	<input type="checkbox"/> Married, Not Living w/Spouse ( <b>voluntarily</b> )	<input type="checkbox"/> Married, Not Living w/Spouse ( <b>involuntarily</b> )	
	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single – Never Married	<input type="checkbox"/> Widowed/Widower	<input type="checkbox"/> Divorced

QUALIFYING ACTIVITY: Check all that apply to your Additional Guardian/Spouse			
<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Job Search	<input type="checkbox"/> Post-Secondary School Student
<input type="checkbox"/> Training/Education	<input type="checkbox"/> English as a Second Language Student	<input type="checkbox"/> GED/High School Equivalency Student	<input type="checkbox"/> Middle / Jr. High Student
<input type="checkbox"/> Disabled	<input type="checkbox"/> National Guard	<input type="checkbox"/> Military Reserves	<input type="checkbox"/> Active Military (serving full time)

Section 4: Child(ren)'s Information – (REQUIRED unless otherwise indicated)			
Complete this section for <u>every</u> child in your home			
*Please include all children in your home regardless of whether or not you are requesting care for them.			
Child Last Name:		Child First Name:	Child Middle Initial:
Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You:

Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien <sup>1</sup>	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines): <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Non-medical Exemption <input type="checkbox"/> No, Medical Exemption <input type="checkbox"/> Other	Does this child have a disability or have additional care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

Section 4 Cont'd: Child(ren)'s Information - Complete this section for <u>every</u> child in your home
*Please include all children in your home regardless of whether you are requesting care for them.

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

Child Last Name:		Child First Name:		Child Middle Initial:
Social Security Number (Optional): ____-____-____	Date of Birth (MM/DD/YYYY): ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You:	

Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien <sup>2</sup>	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines): <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Non-medical Exemption <input type="checkbox"/> No, Medical Exemption <input type="checkbox"/> Other	Does this child have a disability or have additional care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

**Section 4 Cont'd: Child(ren)'s Information - Complete this section for every child in your home**  
**\*Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:		Child First Name:		Child Middle Initial:
Social Security Number (Optional): ____-____-____	Date of Birth (MM/DD/YYYY): ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You:	

Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien <sup>3</sup>	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---	---

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines): <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Non-medical Exemption <input type="checkbox"/> No, Medical Exemption <input type="checkbox"/> Other	Does this child have a disability or have additional care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

<sup>2</sup> "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.  
<sup>3</sup> "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.

**Section 4 Cont'd: Child(ren)'s Information - Complete this section for every child in your home**  
**\*Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:
Social Security Number (Optional): ____-____-_____	Date of Birth (MM/DD/YYYY): ____/____/_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to You:		

Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Non-citizen <input type="checkbox"/> Qualified Alien <sup>4</sup>	Race (optional, mark all that apply):	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity (optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
		<input type="checkbox"/> Asian	<input type="checkbox"/> Black	

Is this a child who is part of a Joint Custody agreement or another case?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting care for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---	---

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines): <input type="checkbox"/> Yes, Immunized <input type="checkbox"/> No, In Process <input type="checkbox"/> No, Non-medical Exemption <input type="checkbox"/> No, Medical Exemption <input type="checkbox"/> Other	Does this child have a disability or have additional care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
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COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN  
 Page \_\_\_\_\_ of \_\_\_\_\_

<sup>4</sup> "Qualified Alien" is a required federal term with a legal meaning that goes beyond lawful permanent resident. It includes other categories, such as asylees, refugees, and Cuban and Haitian entrees, among others. 8 U.S.C. § 1641.



**Section 5: Your Work/Self-Employment Income**

**REQUIRED:** Do you have work or self-employment income?  Yes  No

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)

If NO, skip to Section 6.

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

*Note: If any of your jobs started within the last 60 days, you may instead provide an employer letter that includes a start date, hourly wage or gross salary amount, hours worked per week, pay frequency, and employer contact information.*

Employer or Business Name	Employer or Business Address and Telephone Number	Work/Self-Employment Start Date	Self-Employed (or 1099)	# of hours per week	How often paid	Total earnings per pay period (including tips & commissions) <b>before taxes</b>
			<input type="checkbox"/> No <input type="checkbox"/> Yes, as an LLC <input type="checkbox"/> Yes, as an S corp			\$
			<input type="checkbox"/> No <input type="checkbox"/> Yes, as an LLC <input type="checkbox"/> Yes, as an S corp			\$

**Section 6: Additional Guardian/Spouse Work/Self-Employment Income**

**REQUIRED:** Does your additional guardian/spouse have work or self-employment income?  Yes  No

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)

If NO, skip to Section 7.

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

*Note: If any of their jobs started within the last 60 days, you may instead provide an employer letter that includes a start date, hourly wage or gross salary amount, hours worked per week, pay frequency, and employer contact information.*

Name of additional guardian/spouse						
Employer or Business Name	Employer or Business Address and Telephone Number	Work/Self-Employment Start Date	Self-Employed	# of hours per week	How Often paid	Total earnings per pay period (including tips & commissions) <b>before taxes</b>
			<input type="checkbox"/> No <input type="checkbox"/> Yes, as an LLC <input type="checkbox"/> Yes, as an S corp			\$
			<input type="checkbox"/> No <input type="checkbox"/> Yes, as an LLC <input type="checkbox"/> Yes, as an S corp			\$

**Section 7: Court Ordered Child Support Paid Out**

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

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

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

**Section 8: Child Support Received and/or Ordered**

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

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

Child Name(s)	Is child support received?	Is child support ordered?	Amount of Child Support Paid	How often paid	How is it paid? (Venmo, cash, check, family support registry (FSR), etc.)	Name of non-custodial parent
	<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 9a: Other Income**

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

**Scan the list of "other income types" below.**

**REQUIRED: Do you or any household members have other types of income?**  Yes  No  
**If you don't see your income type included in the list below, write it in in the "other" spaces at the bottom.**

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

Your Other Income:

Your Other Income Type	Mark if Receiving	Begin Date	Expected End Date	Amount	How often is the income amount received? (weekly, monthly, annually, etc.)
Alimony/Maintenance	<input type="checkbox"/>				
Cash Contributions	<input type="checkbox"/>				
Gifts	<input type="checkbox"/>				

"In-Kind" (a benefit received for work that is not money, i.e. work for free housing or clothes)	<input type="checkbox"/>				
Social Security (Survivor's, Disability, Retirement)	<input type="checkbox"/>				
Supplemental Security Income (SSI)	<input type="checkbox"/>				
Unemployment Compensation	<input type="checkbox"/>				
Veteran's Benefits	<input type="checkbox"/>				
Other Income (List Type):					
Other Income (List Type):					

**Additional Guardian/Spouse's Other Income:**

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

**Child's Other Income (Don't include child support covered in Sec. 8)** Child's Name:

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

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

**Section 9b: Assets (resources, belongings, valuables, etc.)****If your countable assets are worth more than \$1,000,000 then you may not be eligible for CCCAP.****REQUIRED: Do you or your additional guardian/spouse have any liquid resources?** Yes No  
**Liquid resources are cash assets that may include (but are not limited to):** cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.**If NO, answer the next question about non-liquid resources.****If YES, you're required to provide the amount of your liquid resources in dollars \$ \_\_\_\_\_****REQUIRED: Do you or your additional guardian/spouse have any non-liquid resources?** Yes No**Non-liquid resources are non-cash assets that may include (but are not limited to):** licensed/unlicensed automobile, RVs, real property, etc.**If NO, skip to Section 10.****If YES, you're required to provide the current dollar value of your non-liquid resources \$ \_\_\_\_\_****Section 10: Training/Education/Teen Parent Education Detail****Talk to your CCCAP specialist to learn about time limits on eligibility for CCCAP under this activity.****REQUIRED: Are you or your additional guardian/spouse participating in a training/education activity?**Yes No**If YES, you're required to complete the following table: (VERIFICATION IS REQUIRED)****If NO, skip to Section 11.**

Individual Name:		Effective Begin Date:	
Training/Education Institution:	Type of Training: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> English As A Second Language (ESL) <input type="checkbox"/> GED/High School Equivalency <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Vocational or Trade School <input type="checkbox"/> Certificate Program <input type="checkbox"/> Post-Secondary Education (first bachelor's degree or less)	Anticipated Completion Date:	Number of Credits (if applicable)
Individual Name:		Effective Begin Date:	
Training/Education Institution:	Type of Training: <input type="checkbox"/> Adult Basic Education <input type="checkbox"/> English As A Second Language (ESL) <input type="checkbox"/> GED/High School Equivalency <input type="checkbox"/> High School/Jr. High <input type="checkbox"/> Job Skills Training <input type="checkbox"/> Vocational or Trade School <input type="checkbox"/> Certificate Program <input type="checkbox"/> Post-Secondary Education (first bachelor's degree or less)	Anticipated Completion Date:	Number of Credits (if applicable)

**Section 11: Disability Detail****REQUIRED: Are you or an additional guardian/spouse disabled?** Yes No**If YES, you're required to complete the following table: (VERIFICATION IS REQUIRED)****If NO, skip to Section 12.**

Name:	Disability Begin Date:
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Disability Type: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary; Anticipated End Date:_____	Is this Individual able to take care of the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Review Due Date <b>(if applicable):</b>
Name:		Disability Begin Date:
Disability Type: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary; Anticipated End Date:_____	Is this Individual able to take care of the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Review Due Date <b>(if applicable):</b>

**Section 12: Employment/Training/School/Job Search Schedule**

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

<i>Example</i>	<i>Mon. 8:00a - 5:00p</i>	<i>Tues. 8:00a - 5:00p</i>	<i>Weds. 8:00a - 5:00p</i>	<i>Thurs. 8:00a - 3:00p</i>	<i>Fri. 8:00a - 5:00p</i>	<i>Sat. 8:00a-12:00p</i>	<i>Sun. 8:00a - 5:00p</i>
<b>YOUR SCHEDULE</b>	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							
<b>ADDITIONAL GUARDIAN/SPOUSE SCHEDULE</b>	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							

If your schedule varies please explain:

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**Section 13: Children's Current Care Schedule (REQUIRED)**

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

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

Is this a new provider? (REQUIRED)  Yes  No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED)  Yes  No If yes, you're required to provide an anticipated Start Date: \_\_\_ / \_\_\_ / \_\_\_

Is this child enrolled in a Head Start/Early Head Start Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_ / \_\_\_ / \_\_\_ End: \_\_\_ / \_\_\_ / \_\_\_

Is this child enrolled in the Universal Preschool Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_ / \_\_\_ / \_\_\_ End: \_\_\_ / \_\_\_ / \_\_\_

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

Is this a new provider? (REQUIRED)  Yes  No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED)  Yes  No If yes, you're required to provide an anticipated Start Date: \_\_\_ / \_\_\_ / \_\_\_

Is this child enrolled in a Head Start/Early Head Start Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_ / \_\_\_ / \_\_\_ End: \_\_\_ / \_\_\_ / \_\_\_

Is this child enrolled in the Universal Preschool Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_ / \_\_\_ / \_\_\_ End: \_\_\_ / \_\_\_ / \_\_\_

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

Is this a new provider? (REQUIRED)  Yes  No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED)  Yes  No If yes, you're required to provide an anticipated Start Date: \_\_\_/\_\_\_/\_\_\_

Is this child enrolled in a Head Start/Early Head Start Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_/\_\_\_/\_\_\_ End: \_\_\_/\_\_\_/\_\_\_

Is this child enrolled in the Universal Preschool Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_/\_\_\_/\_\_\_ End: \_\_\_/\_\_\_/\_\_\_

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

Is this a new provider? (REQUIRED)  Yes  No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED)  Yes  No If yes, you're required to provide an anticipated Start Date: \_\_\_/\_\_\_/\_\_\_

Is this child enrolled in a Head Start/Early Head Start Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_/\_\_\_/\_\_\_ End: \_\_\_/\_\_\_/\_\_\_

Is this child enrolled in the Universal Preschool Program?  Yes  No If yes, what is their enrollment start date and end date? Start: \_\_\_/\_\_\_/\_\_\_ End: \_\_\_/\_\_\_/\_\_\_



Notice and Acknowledgement of Data Sharing

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

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

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

- Any child care provider I may choose to use,
- Any employer for whom I currently work or have worked,
- Any documentation submitted for self-employment,
- Any school or training institution I may be attending,
- Any other governmentally-administered assistance program – including any entity directly involved in the administration or delivery of said governmentally-administered assistance program – including, but not limited to, Head Start, Early Head Start, and the Colorado Universal Preschool Program.

## LOW-INCOME CHILD CARE CLIENT RESPONSIBILITIES AGREEMENT

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

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

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

1. If myself or any teen parent or additional guardian/spouse in my child care case is self-employed I/we must maintain an average income that exceeds business expenses and I agree to track and verify income, expenses, work schedule and need for care to assist in my eligibility determination.
2. If child care is provided for an employment or self-employment activity then the taxable gross wages divided by the number of hours worked must equal at least the current federal minimum wage in order to continue receiving child care. If a self-employment endeavor is less than twelve (12) months old and I am not making minimum wage, I will communicate this to my child care worker so that I may utilize the Self-Employment Launch Period.
3. My parent fee is based on countable household income, household size and number of children in care and is subject to change. I will be notified of my new parent fee at the time of application or re-determination; or, when a reduction/increase of household parent fee occurs.
4. If I do not pay my parent fee or make acceptable payment arrangements with my child care provider, I will lose my child care benefits at re-determination and will not be able to receive child care assistance with another child care provider and/or through any other county.
5. If myself or an additional guardian/spouse in my child care case is found to have intentionally given false information by deed or omission, my child care household cannot get child care assistance for twelve (12) months for the first offense, twenty-four (24) months for the second offense, and permanently for the third offense. This crime is subject to prosecution under federal and state laws.

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

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Additional Guardian/Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

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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  
4<sup>th</sup> Floor  
Denver, CO 80203

2. You must appeal the county decision within 15 days of the mail date on the Notice of County Hearing Decision.
3. In the letter you need to state that you want to appeal the county hearing decision and why you want to appeal the decision. If you need help doing this you can ask anyone to help you, or talk to a legal aid office, or ask your County Social/Human Services representative to help you.
4. The Office of Administrative Courts will schedule a date for the appeal hearing if it is determined the request was filed timely. You will receive a letter from the Office of Administrative Courts explaining the next steps, who may come with you, who may present testimony and other information about the hearing.

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

#### Discrimination

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

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

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

Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

Keep this page for your reference





# MESA COUNTY WORKFORCE CENTER

512 29 1/2 Rd, Grand Junction, CO 81504  
Mailing Address: P.O. Box 20,000, Grand Junction, CO 81502  
Telephone: (970) 248-0871; Fax: (970) 255-3616

## STATEMENT OF PARENTING PLAN

**Name of CCAP Applicant:** \_\_\_\_\_

**Name of Father and/or Mother (not in home):** \_\_\_\_\_

**Name of child/ren:** \_\_\_\_\_  
\_\_\_\_\_

**Do you have 100% custody of child/ren?** \_\_\_\_ Yes \_\_\_\_ No

If No, complete the following: (If Yes, print name and sign below and no further action is required.)

### If there is shared parenting plan in place please describe:

List the day and time of the exchange. **Effective date:** \_\_\_\_\_

Date	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Explain plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CCAP Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Applicant Name:** \_\_\_\_\_







**MESA COUNTY WORKFORCE CENTER**  
 512 29 1/2 Rd, Grand Junction, CO 81501  
 Mailing Address: P.O. Box 20000, Grand Junction, CO 81502-5035  
 Telephone: (970) 248-0871; Fax: (970) 255-3613

**Employment Status Verification**      *(Must be completed by employer)*

Name of Employee: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_

Name of Company: \_\_\_\_\_

Address of Company: \_\_\_\_\_

**Employer Signature X** \_\_\_\_\_ Date \_\_\_\_\_

**Print Employer Name** \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Start Date: \_\_\_\_\_ Date of First Check: \_\_\_\_\_ Rate Per Hour \$ \_\_\_\_\_

Hours per week \_\_\_\_\_ Anticipated Weekly Tips \$ \_\_\_\_\_ Monthly Salary \$ \_\_\_\_\_

How Often Paid: Weekly \_\_\_\_\_ Bi-Weekly \_\_\_\_\_ Twice monthly \_\_\_\_\_ Monthly \_\_\_\_\_

Commission only \_\_\_\_\_ Base + commission \_\_\_\_\_

Other: \_\_\_\_\_

Anticipated Gross income on first check (for new employee) \$ \_\_\_\_\_

Total gross income for the month of \_\_\_\_\_ was \$ \_\_\_\_\_

**Employment Schedule Effective Date:** \_\_\_\_\_ **# Days worked per week:** \_\_\_\_\_

Example	Mon. 8am – 5pm	Tues. 8am-5pm	Weds. 8am-5pm	Thurs. 8am-5pm	Fri. 8am-5pm	Sat. 8am-5pm	Sun. 8am-5pm
<b>Schedule</b>	<b>Mon.</b>	<b>Tues.</b>	<b>Weds.</b>	<b>Thurs.</b>	<b>Fri.</b>	<b>Sat.</b>	<b>Sun.</b>
Schedule Time in/out							

**(If schedule is alternating, list second schedule)**

Example	Mon. 8am – 5pm	Tues. 8am – 5pm	Weds. 8am – 5pm	Thurs. 8am – 5pm	Fri. 8am – 5pm	Sat. 8am – 5pm	Sun. 8am – 5pm
<b>Schedule</b>	<b>Mon.</b>	<b>Tues.</b>	<b>Weds.</b>	<b>Thurs.</b>	<b>Fri.</b>	<b>Sat.</b>	<b>Sun.</b>
Schedule Time in/out							

(If schedule varies, **please give examples** of shifts and # of days of the week, list any set days off.)

Comments: \_\_\_\_\_

**If no longer employed:**

Last day worked: \_\_\_\_\_ Gross of last check \$ \_\_\_\_\_ Date of last check \_\_\_\_\_

Reason job ended: \_\_\_\_\_

**Return to:** Workforce Center \_\_\_\_\_ Telephone # \_\_\_\_\_ Fax # 970-255-3613

