

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

All eligibility criteria must be met for you to qualify and receive assistance.

Intake Completed By: _____

Worker:

Application for Child Care Services

Case #:

Log #:

Application Date:

You MUST answer all YES or NO questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing!

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

Please provide your information here:

Last Name:		First name:		Middle Initial:	
Social Security Number: ____-____-_____ <small>(This information is voluntary and for informational purposes, however it will be used for verification.)</small>		Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
County:	Home Phone: ()	Work Phone: ()	Message Phone: ()		
Residence Address:		Apt/Unit	Mailing Address (if different):		
City:	State:	Zip:	City:	State:	Zip:

What is: (check all that apply to you) Optional

Your ethnicity	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic or Latino			
Your race	<input type="checkbox"/> American Indian/Alaskan native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American		
	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White/Caucasian			
Your current marital status?	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed

Check all the activities that you are doing:

<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Looking for a job	<input type="checkbox"/> Incapacitated	<input type="checkbox"/> Job Training	
<input type="checkbox"/> Junior High/High School	<input type="checkbox"/> GED	<input type="checkbox"/> Adult Basic Education	<input type="checkbox"/> English as a second language	<input type="checkbox"/> Post-Secondary School	
Are you attending school/Training?	<input type="checkbox"/> Yes (If yes complete the information below.)			<input type="checkbox"/> No	
What is your current education level?					
Name of School/Training Facility		Degree/Certificate	Hours per week	Start Date	End Date

Have you recently applied for or are you receiving TANF/Colorado Works?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are any of your children receiving assistance but you are not?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing!

Spouse and/or Other Adult Caretaker Information

Is there a spouse/other adult caretaker in the household who provides financial assistance and helps care for your child?	<input type="checkbox"/> Yes (If yes complete the section below.)	<input type="checkbox"/> No
Last Name:	First name:	Middle Initial:
Social Security Number: ____-____-_____ (This information is voluntary and for informational purposes, however it will be used for verification.)	Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
What is: (check all that apply to you) Optional		
Your ethnicity	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic or Latino
Your race	<input type="checkbox"/> American Indian/Alaskan native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White/Caucasian	
Your current marital status?	<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	

Check all the activities that you are doing:				
<input type="checkbox"/> Employed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Looking for a job	<input type="checkbox"/> Incapacitated	<input type="checkbox"/> Job Training
<input type="checkbox"/> Junior High/High School	<input type="checkbox"/> GED	<input type="checkbox"/> Adult Basic Education	<input type="checkbox"/> English as a second language	<input type="checkbox"/> Post-Secondary School

Are you attending school/Training?	<input type="checkbox"/> Yes (If yes complete the information below.)	<input type="checkbox"/> No		
What is your current education level?				
Name of School/Training Facility	Degree/Certificate	Hours per week	Start Date	End Date

Shared Parenting Time Schedule (Verification is required)

Child Name	√ if this child spends no time w/other parent.	Please indicate days and times child is in the other parent's home.						
		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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

Children and other household member information: (You must verify citizenship status for children receiving child care.)											
Last Name, First Name, Middle Initial	Relation to You (use code below)	Gender (M/F)	Date of Birth	Social Security Number (This information is voluntary, but will be used for verification.)	Is this child a U.S. Citizen?	Is this child a qualified Alien?	Ethnicity (E) Code (Optional) (Use code below)	Race (R) Code (Optional) Use code below	Is care requested for this child?	Immunization Codes. (Use code below)	Does this child have special needs?
					Yes No	Yes No			Yes No		Yes No
					Yes No	Yes No			Yes No		Yes No
					Yes No	Yes No			Yes No		Yes No
					Yes No	Yes No			Yes No		Yes No
					Yes No	Yes No			Yes No		Yes No
					Yes No	Yes No			Yes No		Yes No

Relation to You:	CB - Biological child	CL - Child w/ legal guardian	CR - Child w/ caretaker relative	CU - Unrelated child	OM - Other member
Ethnicity Code (E):	H - Hispanic/Latino	N - Non-Hispanic/Latino			
Race Codes (R):	A -Asian	B -Black/African American	I -American Indian/Alaskan Native	P Native Hawaiian/Other Pacific Islander	W -White
Immunization Codes:	IM : Child Immunized	ME : Medical Exemption	RE : Religious Exemption	OT : Other (explain)	

You **MUST** answer all **YES or NO** questions, sign and date this form.

Any question answered with N/A will be considered incomplete and may delay application processing!

Children's Schedule for children needing care. (Do not complete for children who do not need care.)

Child Name	Child In School	School Of Attendance	Child's Schedule: Please indicate times you plan to have your child in care each day for each provider used (if more than one). Note that care will be approved based on eligibility.							
			Name, Address and Phone # of Child Care Provider (If known)	Mon. <i>Start and end time</i>	Tues. <i>Start and end time</i>	Wed. <i>Start and end time</i>	Thurs. <i>Start and end time</i>	Fri. <i>Start and end time</i>	Sat. <i>Start and end time</i>	Sun. <i>Start and end time</i>
	Yes No									
	Yes No									
	Yes No									
	Yes No									
	Yes No									

ADULT CARETAKER(S) EMPLOYMENT/TRAINING/SCHOOL OR 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.)**

MY SCHEDULE	Mon. <i>Start and end time</i>	Tues. <i>Start and end time</i>	Weds. <i>Start and end time</i>	Thurs. <i>Start and end time</i>	Fri. <i>Start and end time</i>	Sat. <i>Start and end time</i>	Sun. <i>Start and end time</i>
Work/Job Search							
Training/School							
2ND ADULT CARETAKER	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun
Work/Job Search							
Training/School							

Court Ordered Child Support Paid Out.

Do you make child support payments for any child(ren) **NOT** living with you? Yes No

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

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

Applicant Work Income

Do you have work income? Yes No

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

Name of person	Employer or Business Name and Telephone Number	Self-Employed	# of hours per week	How often paid	Total earnings per pay period (including tips & commissions)
		Yes No			\$
		Yes No			\$
		Yes No			\$

Spouse or Other Adult Caretaker Work Income

Do you have work income? Yes No

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

Name of person	Employer or Business Name and Telephone Number	Self-Employed	# of hours per week	How often paid	Total earnings per pay period (including tips & commissions)
		Yes No			\$
		Yes No			\$
		Yes No			\$

Child Support Ordered and/or Received

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

If YES complete the following: (VERIFICATION OF CHILD SUPPORT IS REQUIRED.)

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

You may reside in a county that requires child support enforcement participation in order to receive Child Care Assistance Benefits. If your county requires this you must cooperate for any child with an absent parent regardless of child care eligibility unless there is good cause. For more details, please contact your local county Child Care Assistance Program office.

Non-work Income

Do you or anyone in your household have non-work income? Yes No

Refugee Cash Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cash contributions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Railroad retirement benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security (Includes Survivor's, Disability, and Retirement Benefits.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dividends from stocks and bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement or pension (Not Social Security)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance/lawsuit settlement/proceeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strike benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Trust income	<input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interest on savings, CDs, IRAs, 401Ks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran's benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alimony/maintenance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lease bonus and royalties	<input type="checkbox"/> Yes <input type="checkbox"/> No	Americorp Income	<input type="checkbox"/> Yes <input type="checkbox"/> No
Annuity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Military allotment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No

If YES complete the following for all members of your household: (VERIFICATION IS REQUIRED.)

Name of person receiving income	Type of income (From above)	How often received? (Monthly, weekly, etc.)	Amount received
			\$
			\$
			\$

Other Income

Do you or anyone in your household have other income? Yes No

If YES complete the following: Complete for all members of your household.

Housing voucher or cash assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refugee medical assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colorado Works/ TANF cash assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Old age pension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, but I would like to apply	Low-income energy assistance (LEAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid/CHP+ Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, but I would like to apply	Supplemental security income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of person receiving income	Type of income (From above)	How often received? (Monthly, weekly, etc.)	

Emergency Contact and Phone Number:

Name	Relationship	Phone

Authorization to Supply Information

I hereby authorize the _____ County Department of Social Services, in the course of administering the social services program, to supply information 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 child care assistance.**

Authorization to Release Information

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

- **Any child care provider I may choose to use,**
- **any employer for whom I 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 child care assistance.**

Signature of Client: _____ Date: _____

Signature of Spouse and/or Other Adult Caretaker: _____ Date: _____

YOU MUST READ AND SIGN THIS PAGE!!!!

RIGHT OF APPEAL AND FAIR HEARING

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

- ◆ If your child care benefits are **denied**, you must call your child care assistance worker within 20 days of the date of the denial to say that you want to appeal.

The county department will schedule a hearing. At the hearing, you will be given an opportunity to present your case. The person(s) reviewing your case is not responsible for the decision or change you disagree with.

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

After you have completed a county hearing or if you wish to skip a county hearing, you may appeal the decision to the State by following these steps:

1. Write a letter to: **Division of Administrative Hearings
633 17th Street, Suite 1300
Denver, Colorado 80202**
2. You must get the letter in the mail no later than 15 days after the county hearing decision has been made.
3. In the letter you need to say that you want to appeal the county hearing decision. Why you want to appeal the decision. If you need help doing this you can ask anyone you desire to help you, talk to a legal aid office, or ask your County Social Services people to help you.
4. When your letter is received, you will get a letter from the Office of Appeals explaining what will be done and the date for the appeal hearing. It will also explain who can come with you, who can present testimony and other information about the hearing.

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

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, CO 80294
(303) 844-2024 or (303) 844-3439 (TDD)

Recipient's Copy of Right of Appeal on next page.

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