COLORADO DEPARTMENT OF HUMAN SERVICES
COLORADO CHILD CARE ASSISTANCE PROGRAM
(CCCAP)

RE-DETERMINATION OF ELIGIBILITY FORM

You received this form so the County Department of Social/Human Services can update your eligibility for child care assistance. Please note that failure to complete a re-determination and to supply required documentation will result in the discontinuation of your child care benefits.

Please complete and return this form as soon as you receive it. If we do not receive this form and all required verification by _____ your CCCAP case will close and child care assistance will no longer be authorized as of _____ .

Section 1:

Date: _____

Primary Adult Caretaker Name: _____ Case #: _____

Residence Address: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact Name: _____ Phone: _____

Has your residence address changed? __Yes __No
If Yes, your new residence address is: _____

Do Any of the following apply to your current living situation?	☐ Living in hotel or motel	☐Living in campground	☐ Living in shelter	☐ Living in substandard housing such as car, park, etc.
	☐ Have a temporary living situation (please explain)		Date living situation began: ____/_____/_____ Anticipated end date: ____/_____/_____	

Section 2:

☐ **EMPLOYMENT (include the last thirty (30) days of pay stubs for verification)**

Primary adult caretaker's name: _____

1. Are you working?

___ Yes If Yes, where? _____ Phone _____
How often are you paid? _____

___ No If no, when did you stop working (date)? _____

2. Do you have a second job?

___ Yes If Yes, where? _____ Phone _____
How often are you paid? _____

___ No

3. Do you have a new job? *(Attach employment verification letter from employer)*

___ Yes If Yes, fill in the following: Start Date _____

___ No Employer's name _____ Phone _____

Is the new job in addition to the old job? ___ Yes ___ No

4. Are there two adult caretakers in your home? (If you are a teen parent do not include your parents)
_____ Yes _____ No **If Yes, answer questions 5 - 7**

Second adult caretaker's name: _____

5. Is he/she working?

___ Yes If Yes, where? _____ Phone _____

How often are you paid? _____

___ No If no, when did you stop working (date)? _____

6. Does he/she have a second job?

___ Yes If Yes, where? _____ Phone _____

How often are you paid? _____

___ No

7. Does he/she have a new job? *(Attach employment verification letter from employer)*

___ Yes If Yes, fill in the following: Start Date _____

___ No Employer's name _____ Phone _____

Is the new job in addition to the old job? ___ Yes ___ No

Section 3:

☐ **EDUCATION/TRAINING**

Primary adult caretaker name: _____

8. Are you in training? _____ Yes _____ No Where? _____

Are you in school? _____ Yes _____ No Where? _____

Second adult caretaker name (If applicable): _____

9. Are you in training? _____ Yes _____ No Where? _____

Are you in school? _____ Yes _____ No Where? _____

Section 4:

☐ **JOB SEARCH/DISABILITY**

Primary adult caretaker name: _____

10. Are you looking for a job? _____ Yes _____ No If yes, start date? _____

Are you disabled? _____ Yes _____ No If yes, start date? _____

If yes, is the disability _____permanent or _____temporary? If temporary, end date? _____

Are you on maternity leave? _____ Yes _____ No If yes, start date? _____

If yes, expected end date? _____

Second adult caretaker name (If applicable): _____

11. Is he/she looking for a job? _____ Yes _____ No If yes, start date? _____

Is he/she disabled? _____ Yes _____ No If yes, start date? _____

If yes, is the disability _____permanent or _____temporary? If temporary, end date? _____

Is he/she on maternity leave? _____ Yes _____ No If yes, start date? _____

If yes, expected end date? _____

Section 5:

☐ **HOUSEHOLD INFORMATION**

List ALL people in your household:

Last Name, First Name, Middle Initial	How related to you?	Gender M/F	Date of Birth	Children's Immunization information: (codes below)
	SELF			

Immunization record codes: **IM**: Child Immunized **ME**: Medical Exemption **RE**: Religious Exemption **OT**: Other (explain)

Are any of the people listed above new to your household? ____Yes ____ No
If yes, complete the following information:

☐ **Newly added adults (If applicable) use additional paper if necessary and include all requested information**

Date Entered Home	Last Name, First Name	Social Security Number (optional)	Military Status	Marital Status (see codes below)	Hispanic or Latino (Y/N)	Race(s) List all that apply, (see codes below)
			☐ Active Military (serving full time) ☐ Military Reserves ☐ National Guard			
			☐ Active Military (serving full time) ☐ Military Reserves ☐ National Guard			

Race codes (use all that apply): **A**-Asian, **B**-Black/African American, **H-** Hispanic I: American Indian/Alaska Native **P**-Native Hawaiian/Other Pacific Islander, **W**-White
Marital Status Codes: D-Divorced, **M**-Married, **S**-Single, **P**-Separated, **W**-Widowed

☐ **Newly added dependents/children (If applicable)**

Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information: (codes below)
If this 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 this child is not 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
Name of Parent(s) outside of household who may have duty for child support: **Last:** _____ **First:** _____								
Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information: (codes below)
If this 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 this child is not 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
Name of Parent(s) outside of household who may have duty for child support: **Last:** _____ **First:** _____								
Date Entered Home	Last Name, First Name	Social Security Number (Optional)	Hispanic or Latino (Y/N)	Race(s) (List all that apply, see codes below)	Care needed for this child? (Y/N)	Disabled child? (Y/N)	Date of Birth	Immunization information: (codes below)
If this 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 this child is not 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
Name of Parent(s) outside of household who may have duty for child support: **Last:** _____ **First:** _____								

Race codes (use all that apply):, **A**-Asian, **B**-Black/African American, **H-** Hispanic **I**: American Indian/Alaska Native **P**-Native Hawaiian/Other Pacific Islander, **W**-White

Immunization record codes **IM**: Child Immunized **ME**: Medical Exemption **RE**: Religious Exemption **OT**: Other (explain)

☐ **Are any of the children listed above not U.S. citizens? ___ Yes ___ No** If yes, please provide the following:

Child's name	Date of Birth	Alien Registration Information
		A
		A

☐ **Are any of the children listed above a part of a Joint Custody or Foster Custody Arrangement?**
___ Yes ___ No If yes, please provide the following:

Child's name	Joint Custody or Foster Custody?	Date Moved into custody arrangement
	□Joint Custody □ Foster Custody	
	□Joint Custody □ Foster Custody	

☐ **Has anyone left your household? ___Yes ___ No** If yes, please provide the following:

Name	Date left	Reason for Leaving

Section 6:

☐ **Other Benefit Program Information**

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 7:

☐ **EMPLOYMENT OR EDUCATION/TRAINING SCHEDULE(S)**

Please fill in your employment or education/training schedule. If there are two adult caretakers in your household, fill in schedules for both adult caretakers. If you have more than one job, please be sure to include schedules for all employment.

Example: Schedule: Hours:	*Mon. (am/pm)* *8:00 - 5:00* *9*	*Tues. (am/pm)* *8:00 - 3:00* *7*	*Weds. (am/pm)* *8:00 - 5:00* *9*	*Thurs. (am/pm)* *8:00 - 3:00* *7*	*Fri. (am/pm)* *8:00 - 5:00* *9*	*Sat.* *0* *0*	*Sun.* *0* *0*
MY SCHEDULE	**Mon.**	**Tues.**	**Weds.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
Work							
# Hours							
Education/Training							
# Hours							
2ND ADULT CARETAKER	**Mon.**	**Tues.**	**Weds.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
Work							
# Hours							
Education/Training							
# Hours							

If your schedule varies please explain: _____

Section 8:

☐ **CHILDREN'S SCHEDULE(S)**

Please fill in each child's schedule. Please indicate when 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 and please attach a copy of each school-aged child's school calendar/schedule.

Child's Name:						Effective Begin Date:	Effective End Date:
Provider Name and License #:							
Provider Address:							
Example: Schedule: Hours:	*Mon. (am/pm) 8:00 - 5:00 9*	*Tues. (am/pm) 8:00 - 3:00 7*	*Weds. (am/pm) 8:00 - 5:00 9*	*Thurs. (am/pm) 8:00 - 3:00 7*	*Fri. (am/pm) 8:00 - 5:00 9*	*Sat. 0 0*	*Sun. 0 0*
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule							
# Hours							

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: ___/____/_____

☐ **CHILDREN'S SCHEDULE(S)**

Please fill in each child's schedule. Please indicate when 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 and please attach a copy of each school-aged child's school calendar/schedule.

Child's Name:						Effective Begin Date:	Effective End Date:
Provider Name and License #:							
Provider Address:							
Example: Schedule: Hours:	*Mon. (am/pm) 8:00 - 5:00 9*	*Tues. (am/pm) 8:00 - 3:00 7*	*Weds. (am/pm) 8:00 - 5:00 9*	*Thurs. (am/pm) 8:00 - 3:00 7*	*Fri. (am/pm) 8:00 - 5:00 9*	*Sat. 0 0*	*Sun. 0 0*
Day	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Schedule							
# Hours							

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: ___/____/_____

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILD SCHEDULES.

Page _____of _____

Section 9:

☐ **INCOME QUESTIONS: List *ALL* income. If there is no income enter a zero.**

Fill in your total family income per month:

Income Type	My Income	2nd Adult caretaker Income	Income Type	My Income	2nd Adult caretaker Income
Wages (before taxes)	$	$	Social Security survivor's benefits, permanent disability insurance payments	$	$
Self-employed income	$	$	Lease bonuses & royalties	$	$
Tips or _____ % Commission	$	$	Military allotments	$	$
Child Support	$	$	Strike benefits	$	$
Alimony Payment	$	$	Dividends, interest, income from estates or trusts, net rental income, royalties	$	$
Liquid Resources (cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc.)	$	$	Retirement and pension payments (Veteran's, Social Security pensions)	$	$
Non-Liquid Resources (licensed/unlicensed automobile, RVs, real property, etc.)	$	$	Unemployment insurance	$	$
Worker's compensation	$	$	Other income	$	$
			TOTAL INCOME	$	$
			TOTAL FAMILY INCOME	$	

☐ **OTHER INCOME (If applicable) Do you or anyone in your household receive any of the following income? If Yes, please complete the table below.**

1. Housing voucher or cash assistance	☐ Yes ☐ No	2. Food stamp assistance	☐ Yes ☐ No ☐ No, I would like to apply	3. Refugee cash assistance or medical assistance	☐ Yes ☐ No
4. Colorado Works/ TANF cash assistance	☐ Yes ☐ No	5. Supplemental Security Income (SSI)	☐ Yes ☐ No	6. Low-income energy assistance (LEAP)	☐ Yes ☐ No
7. Old age pension	☐ Yes ☐ No	8. Americorp Income	☐ Yes ☐ No		

Name of person receiving income	Type of income (use number from above)	How often received? (Monthly, weekly, etc.)

Other changes or comments you want to make:

_____

_____

_____

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 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 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 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.

YOU MUST READ AND SIGN THIS PAGE

You must submit the following documentation with this form:
IF YOU ARE WORKING YOU NEED TO INCLUDE:

- ➔ For self-employed persons, a business ledger and copies of your total business earnings, your business expenditures for the last thirty (30) days, and your expected work schedule. (Please be aware that you must make a profit and you must meet the current Federal Minimum wage to remain eligible.)

- ➔ Income verification and verification of the work schedule. You must attach copies of all household members' **pay stubs from the last thirty (30) days.** Please be aware that you must meet the current Federal Minimum Wage to remain eligible.

If you just started a new job, you must provide a completed copy of the employment verification letter including: your start date, your wages, your schedule, number of hours/days you work per week, how often you will be paid, and the date of your first paycheck.

If you lose your job and need child care assistance while looking for work, Job Search Child Care is available on a LIMITED basis and you must have prior approval to use child care services for Job Search.

IF YOU ARE REQUESTING CARE FOR EDUCATION/TRAINING, YOU NEED TO INCLUDE:

- ➔ A letter from your education/training institution which
  (1) Verifies you are enrolled and making satisfactory progress.
  (2) Identifies the program you are enrolled in, and
  (3) Identifies when you are expected to complete the program.
  (4) Start and end dates of quarter, semester, or session;
  (5) Days/time of class and
  (6) Number of credits.

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.

Completion Checklist Did you:					
	Complete Re-determination		Attach required pay stubs		Attach employment verification letter (if new employment)
	Sign and date Re-determination		Attach all training information		Attach verification of any other income
	Attach work or education/training schedule		Attach all education information		

I certify that the information on this form is correct, to the best of my knowledge. I understand that failure to report 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

☒ _____ _____ _____
Primary Adult Caretaker Signature **Daytime Phone** **Date**

☒ _____ _____ _____
Other Adult Caretaker Signature **Daytime Phone** **Date**

IMPORTANT REMINDERS:

A person found to have intentionally given false information by deed or omission cannot get child care assistance in Colorado for twelve (12) months for the first offense, twenty-four (24) months for the second offense, and permanently for the third offense. This crime is subject to prosecution under federal and state laws.

You must report changes to income where the total income exceeds eighty-five per cent (85%) of the State Median Income, in writing, within ten (10) calendar days of the change. You must also report if you are no longer in your eligible activity, in writing, within four (4) calendar weeks.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social/human services.

Until you are approved for the Child Care Assistance Program you are responsible for the cost of child care. Please ask your eligibility worker for details.

After you are approved for the Child Care Assistance Program you are responsible for payment of Parental Fees (if applicable) to your Provider. Please ask your eligibility worker for details.

To remain eligible for the Child Care Assistance Program you are responsible for providing all required information to complete your re-determination. Please ask your eligibility worker for details.

A Change of Eligibility form can be obtained from the Colorado Child Care Assistance Program at your county department of social/human services.

Until you are re-determined as eligible for the Child Care Assistance Program you are responsible for the cost of child care.

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.