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

Application for Colorado Child Care Assistance Program. (CCCAP)

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

Section 1: Household Information

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

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

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

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

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

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

Section 2: Primary Caretaker Information

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

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

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

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

ACTIVITY: Check all that apply to this individual			
□ Employed	□ Self-Employed	□ Job Search	□ Post-Secondary School
□ Training/Education	□ English as a second language	□ GED/High School Equivalency	□ Middle / Jr. High
□ Disabled	□ National Guard	□ Military Reserves	□ Active Military (serving full time)

Section 3: Additional Adult Caretaker/Spouse

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

Last Name:	First Name:	Middle Initial:

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

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

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

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

ACTIVITY: Check all that apply to this individual			
□ Employed	□ Self-Employed	□ Job Search	□ Post-Secondary School
□ Training/Education	□ English as a second language	□ GED/High School Equivalency	□ Middle / Jr. High
□ Disabled	□ National Guard	□ Military Reserves	□ Active Military (serving full time)

Section 4: Child Information Complete this section for each child in your home

Last Name:	First Name:	Middle Initial:

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

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

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

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

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

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

Section 4 Cont'd Complete this section for each child in your home

Last Name:	First Name:	Middle Initial:

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

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

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

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

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

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

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

Last Name:	First Name:	Middle Initial:

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

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

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

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

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

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

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

Last Name:	First Name:	Middle Initial:

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

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

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

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

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

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

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN

Page _____of _____

Section 5: Primary Caretaker Work/Self-Employment Income

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

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

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

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

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

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

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

Section 7: Court Ordered Child Support Paid Out

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

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

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

Section 8: Child Support Ordered and/or Received

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

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

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

COPY THIS PAGE AS NEEDED FOR ADDITIONAL HOUSEHOLD MEMBERS

Page _____of _____

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

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

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

Name:	Effective Begin Date:	Effective End Date:

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

Name:	Effective Begin Date:	Effective End Date:

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

Section 11: Adult Caretaker Disability Detail

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

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

Name:	Disability Begin Date:	Disability End Date:

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

Name:	Disability Begin Date:	Disability End Date:

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

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

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

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

Section 13: Children's Schedule for children needing care

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

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

Authorization to Supply Information

Authorization to Supply Information

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

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

Authorization to Release Information

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

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

☒Signature of Client: _____ Date: _____

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

LOW-INCOME CHILD CARE CLIENT RESPONSIBILITIES AGREEMENT

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

1. To notify my child care worker in writing within ten (10) calendar-days if my total household income exceeds 85% of the State Median Income (SMI) and report within four (4) weeks if my qualifying eligible activity changes. I understand that I must also verify these changes and that I will have to repay any benefits I received for which I was not eligible. Income amounts by household size can be found at www.coloradoofficeofearlychildhood.com.

2. To complete the re-determination process, including providing a complete re-determination packet and all required verification, when it is due, in order to maintain my CCCAP benefits.

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

4. I agree to provide my child care worker with immunization records for my child(ren) if they are not yet school-age and care is provided outside of my home by an unrelated, Qualified Exempt Child Care Provider.

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

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

7. To use the State approved Attendance Tracking System (ATS) as designed to check my child(ren) in and out of child care on the days that my child(ren) attends child care. If my child care provider has a state approved ATS waiver, I will check my child(ren) in and out as instructed by my child care worker and/or provider.

8. To not share my Attendance Tracking System Personal Identification Number (PIN) with my child care provider or any other individual and to notify my child care worker if my child care provider asks for this information.

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

10. If my CCCAP case closes and less than thirty (30) days have passed from date of closure before I have provided the verification needed to correct the reason for closure, services may resume as of the date the verification was received by the county. I also understand that I would be responsible for payment during the gap in service.

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

1. If myself or any teen parent or adult caretaker on my child care case is self-employed I/we must maintain an average income that exceeds business expenses and I agree to track and verify income, expenses, work schedule and need for care to assist in my eligibility determination.

2. If child care is provided for an employment or self-employment activity then the taxable gross wages divided by the number of hours worked must equal at least the current federal minimum wage in order to continue receiving child care. If a self-employment endeavor is less than twelve (12) months old and I am not making minimum wage, I will communicate this to my child care worker so that I may utilize the Self-Employment Launch Period.

3. My parent fee is based on countable household income, household size and number of children in care and is subject to change. I will be noticed of my new parent fee at the time of application or re-determination; or, when a reduction/increase of household parent fee occurs.

4. If I do not pay my parent fee or make acceptable payment arrangements with my child care provider, I will lose my child care benefits at re-determination and will not be able to receive child care assistance with another child care provider and/or through any other county.

5. If myself or another caretaker on my child care case is found to have intentionally given false information by deed or omission, my child care household cannot get child care assistance for twelve (12) months for the first offense, twenty-four (24) months for the second offense, and permanently for the third offense. This crime is subject to prosecution under federal and state laws.

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

☒Signature of Primary Adult Caretaker: _____ Date: _____

☒Signature of Other Adult Caretaker: _____ Date: _____

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

RIGHT OF APPEAL AND FAIR HEARING

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

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

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

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

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

1. Write a letter to:

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

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

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

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

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

Discrimination

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

Office for Civil Rights

U.S. Department of Health & Human Services

1961 Stout Street – Room 1426

Denver, Colorado 80294

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

Keep this page for your reference