COLORADO DEPARTMENT OF HUMAN SERVICES
CHILD CARE ASSISTANCE PROGRAM

REDETERMINATION 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 redetermination and to supply required documentation will result in the discontinuation of your child care benefits.

All items marked with an * on this re-determination form MUST be completed.
N/A is not acceptable, any question answered with N/A will be considered incomplete.

Please complete and return this form as soon as you receive it. If we do not receive this form and all verification by _____ your child care arrangements will be terminated by _____ [Volume 3, Section 3.921].

Section 1:

Primary Adult Caretaker Name*: _____ Case #: _____

Address*: _____ Date*: _____

_____ Child Care Worker: _____

Phone*:_____ Worker Phone: _____

Has your address changed*? __Yes __No
If Yes, your new street address is:

_____

_____
city, state, zip code Phone

Section 2:

☐ **EMPLOYMENT* (include the last three full months 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 (This information is voluntary and for information purposes only)	Marital Status (see codes below)	Hispanic or Latino (Y/N)	Race(s) List all that apply, (see codes below)

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 (This information is voluntary and for information purposes only)	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)
1.								
1a. Name of Parent(s) outside of household who may have duty for child support: Last: _____ First: _____								
2.								
2a. Name of Parent(s) outside of household who may have duty for child support: Last: _____ First: _____								
3.								
3a. 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

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

Name*	Date left*	Reason for Leaving*

Section 6:

☐ **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 7:

☐ **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*:							
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*							

☐ **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*:							
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*							

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILD SCHEDULES.

Page _____of _____

Section 8:

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

Fill in your total family income per month*:

	My Income	2nd Adult caretaker Income		My Income	2nd Adult caretaker Income
Wages (before taxes)*	$_____	$_____	Life & health insurance proceeds*	$_____	$_____
Self-employed income*	$_____	$_____	Inheritance, cash, gifts, or prizes*	$_____	$_____
Tips or _____ % Commission	$_____	$_____	Social Security survivor's benefits, permanent disability insurance payments*	$_____	$_____
Child Support*	$_____	$_____			
Alimony Payment*	$_____	$_____	Lease bonuses & royalties*	$_____	$_____
Unemployment insurance*	$_____	$_____	Military allotments*	$_____	$_____
Worker's compensation*	$_____	$_____	Strike benefits*	$_____	$_____
Retirement and pension payments* (Veteran's, Social Security pensions)	$_____	$_____			
Dividends, interest, income from estates or trusts, net rental income, royalties*	$_____	$_____	TOTAL INCOME*	$_____	$_____
Other income*	$_____	$_____	TOTAL FAMILY INCOME*	$_____	

SEND IN VERIFICATION OF ALL YOUR 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.)

Emergency Contact and Phone Number*:

Name* Relationship* Phone*

Other changes or comments you want to make:

_____

_____

_____

_____

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 obtained directly from me, or from any other person, agency, or institution which provided information to the county department with my written consent.

I understand that:

The county department is authorized to release the following information:

- The Authorization start and end dates;
- Each child's authorized care schedule, including the number of hours per day;
- The amount of the Parental Fee.

And that the county department is authorized to release the information above to the following:

- Any child care provider I may choose to use;
- Any employer for whom I work;
- Any school or training institution I may be attending.

I release the county department from any and all liability for supplying such information.

☒ Signature of Primary Adult Caretaker: _____ Date: _____

☒ Signature of Other Adult Caretaker: _____ Date: _____

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 work;
- Any documentation submitted for self-employment;
- Any school or training institution I may be attending;
- Any other person, agency or institution that may be pertinent, including housing authorities.

☒ Signature of Primary Adult Caretaker: _____ Date: _____

☒ Signature of Other Adult Caretaker: _____ Date: _____

CLIENT RESPONSIBILITIES AGREEMENT

_____ County Department of Social/Human Services Case # _____

I, _____ and _____,

____ 1. I agree to notify my child care worker in writing within ten (10) days if my total household income exceeds 85% of the State Median Income 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. For my household size of _____ the State Median Income is $_____.

___ 2. I agree that I must complete the redetermination process when it is due, including all required verification.

___ 3. I agree that I must verify my eligible activity. (By providing education/training or work schedules at re-determination and whenever my activity changes.)

___ 4. I agree that I will provide job search logs at least every two weeks outlining my job search efforts or my child care will stop for not being in an eligible activity.

___ 5. I agree that if I am in education/training, county option, that I will maintain satisfactory progress to remain eligible for child care assistance for this activity. Satisfactory progress is a GPA of at least a 2.0 or its equivalent or have academic standing consistent with the institution's graduation requirements.

___ 6. I agree to notify my child care worker in writing at least ten (10) days **BEFORE** changing child care providers otherwise the county may not pay for my child care.

___ 7. I agree to be responsible for resolving any problems I might have with my child care provider.

___ 8. I agree to notify the county department of social/human services if I have any concerns about possible abuse or neglect of a child while in child care.

___ 9. I understand that if any parent in my household 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. I also understand that I must provide documentation from the IRS or other government agency to verify my self-employment status.

___ 10. I understand that if child care is provided for my employment activity then the taxable gross wages divided by the number of hours I use child care for my employment must equal at least the current federal minimum wage in order to continue receiving child care.

___ 11. I agree that if my county requires child support enforcement I will cooperate with the child support enforcement office for any child that has an absent parent regardless of whether they receive child care assistance.

___ 12. I agree that I will not leave my CCAP card in the possession of my child care provider at any time or I will be disqualified from the Colorado Child Care Assistance Program.

____ 13. I agree to use my CCAP card to check my child(ren) in and out of care daily or my child care assistance case will close and I shall be responsible for payment of the child care costs.

____ 14. **I understand that a person found to have intentionally given false information by deed or omission 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.**

____ 15. PARENTAL FEE:

- ____ a. I agree to pay the parental fee listed on my child care authorization notice and that it is due to the provider on the first day of each month.
- ____ b. I understand that my parental fee is based on my income, household size and number of children in care and is subject to change upon receiving prior notice from the county.
- ____ c. I understand that if I do not pay this fee to my child care provider I will lose my child care benefits.
- ____ d. I understand that if I request assistance with another child care provider or move to another county and I still owe fees to any previous provider, I will not receive assistance until satisfactory repayment arrangements have been made with the previous provider.

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 three months, and your expected work schedule. (Please be aware that you must make a profit and your taxable net income divided by the number of hours your child is in care must equal 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 three full months**! (Please be aware that your gross income divided by the number of hours your child is in care must equal 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 exact schedule, number of hours/days you work per week, how often you will be paid, and the date of your first paycheck. Save your paystubs because you will need to submit three months worth of paystubs once you have them available.

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: (Not all counties consider education/training an eligible activity. Check with your county when you complete the redetermination to see if you are eligible for care while in education/training.)

- ➔ 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 redetermination	☐	Attach required pay stubs	☐	Attach employment verification letter (if new employment)
☐	Sign and date redetermination	☐	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.

Page intentionally left blank

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**
   633-17th St, 13th Floor
   Denver, CO 80202

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.