For CCCAP Staff to Complete:		
Application Received Date:	**Pre-Eligibility:** ◯ Yes ◯ No **Determined by:** ◯ Provider ◯ County	**Case Number:**

Application for Colorado Child Care Assistance Program (CCCAP)

Definitions:

- **You** = The parent or primary guardian completing the application.
- **Primary Guardian** = An adult, not the parent, legally responsible for caring for a child.
- **Teen Parents** = a person under twenty-one (21) years of age who is financially contributing to the welfare of the child and is the parent, adoptive parent, step-parent, legal guardian, or person who is acting in “loco parentis,” has custody of the child(ren) for the period that care is requested and is in an eligible activity such as attending basic education, employment, self-employment, or job search.
- **Additional Guardian/Spouse** = A person who lives in your house that cares for your children and/or provides financial assistance and support. This is a person who is assuming the parent obligations for a minor, including protecting their rights and/or a person who is standing in the role of the parent of a minor without having gone through the formal adoption process.

Instructions:

- This application must be submitted by the parent or primary guardian of the children needing child care.
- Completing this application does not guarantee child care assistance.
- All eligibility criteria must be met for you to qualify and receive assistance.
- Please address each section and provide all requested information.
- Missing information will delay your application.
- Teen Parents: Do not include information about your parents even if you live with them.

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

TABLE OF CONTENTS

Section 1: Your Household Information (REQUIRED)

Today's Date:	Are you the parent or primary guardian of the child(ren) for whom you are applying?	Is there an Additional Guardian/Spouse in the household?
	◯ Parent ◯ Primary Guardian	◯ Yes ◯ No

Your Last Name:	Your First Name:	Your Middle Initial:

Do any of the following describe where you live?

◯ Living in hotel or motel ◯ Living in campground ◯ Living in shelter ◯ Living in someone else's home due to housing loss, economic struggles, etc. ◯ Living in substandard housing such as car, park, abandoned building, etc. ◯ Other temporary living situation (please explain): ◯ None apply

Date living situation began:	Anticipated end date (if known):

Physical Address:	Mailing Address: ☐ Same as physical address?

City:	State:	Zip:	City:	State:	Zip:

County:	County:

Contact Information: ***Complete at least one***	Email (required)	Primary Phone: Type: ◯ Home ◯ Cell ◯ Voice Message ◯ Work	Secondary Phone: Type: ◯ Home ◯ Cell ◯ Voice Message ◯ Work

Preferred Contact Method:	Preferred Language Spoken at Home:
◯ Phone ◯ Email ◯ Mail	

There are other programs that can benefit you and your family.

So that we can connect you to those programs, please select one of the three options below for each program: I participate; I'd like to learn more; or I am not interested.

*If you select that you would like to learn more, you will be connected to those programs to complete their referral or application processes to see if you qualify.

Head Start/Early Head Start Education Programs: free, quality education for children 0 to 5 years old (***not available in all communities***).	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Early Intervention Colorado: developmental supports available at no cost for children birth up to 3 years old	◯ I participate ◯ I'm not interested ◯ I'd like to learn more because I am concerned about my birth up to 3-year-old child's development.
Preschool Special Education: education supports available at no cost for 3- to 5-year-olds	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Colorado Works/Temporary Assistance for Needy Families (TANF) Cash Assistance: cash assistance for those who qualify	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Food Assistance (SNAP): assistance buying food	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Women, Infants and Children (WIC) Food and Nutrition Program: food, nutrition, and breastfeeding supports for you and your 0-5-year-old child(ren)	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Medicaid/CHP+ Health Insurance Assistance: health coverage for those who qualify.	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Housing Choice Voucher or cash assistance: assistance paying my rent or utilities	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Low-Income Energy Assistance (LEAP): assistance paying my heating bill	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Refugee Medical Assistance: medical assistance for refugees	◯ I participate ◯ I'd like to learn more ◯ I'm not interested
Child Support Services: Services that make sure that children receive regular financial support from both parents.	◯ I participate ◯ I'd like to learn more ◯ I'm not interested

Section 2: Your Information (REQUIRED unless otherwise indicated)

Your Social Security Number **(optional)**:

Your Date of Birth (MM/DD/YYYY):

Your Gender:

◯ Male ◯ Female

Race (**optional, mark all that apply**):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian or Pacific Islander
- ☐ Black
- ☐ Other

Ethnicity (**optional**):

- ☐ Hispanic
- ☐ Non-Hispanic

Highest Grade Completed:

- ☐ Less Than High School/High School Equivalency
- ☐ High School/High School Equivalency
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Ph.D./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

QUALIFYING ACTIVITY: Check all that apply to you

- ☐ Employed
- ☐ Self-Employed
- ☐ Job Search
- ☐ Training/Education
- ☐ Substance Use Disorder Treatment Program
- ☐ Middle / Jr. High Student
- ☐ Disabled
- ☐ National Guard
- ☐ Military Reserves
- ☐ Active Military (serving full time)

Section 3: Additional Guardian/Spouse's Information

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

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

Guardian/Spouse Last Name:	Guardian/Spouse First Name:	Guardian/Spouse Middle Initial:

Social Security Number (**optional**):	Date of Birth (MM/DD/YYYY):	Gender: ◯ Male ◯ Female	Relationship to you:

Guardian/Spouse Email Address (**optional**):

Race (**optional, mark all that apply**)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian or Pacific Islander
- ☐ Black
- ☐ Other

Ethnicity (**optional**):

- ☐ Hispanic
- ☐ Non-Hispanic

Highest Grade Completed:

- ☐ Less Than High School/High School Equivalency
- ☐ High School/High School Equivalency
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Ph.D./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

QUALIFYING ACTIVITY: Check all that apply to your Additional Guardian/Spouse

- ☐ Employed
- ☐ Self-Employed
- ☐ Job Search
- ☐ Training/Education
- ☐ Substance Use Disorder Treatment Program
- ☐ Middle / Jr. High Student
- ☐ Disabled
- ☐ National Guard
- ☐ Military Reserves
- ☐ Active Military (serving full time)

Section 4: Child(ren)'s Information – (REQUIRED unless otherwise indicated)

Complete this section for EVERY child in your home

***Please include all children in your home regardless of whether or not you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number (**Optional**):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to You:
		◯ Male ◯ Female	

Citizenship Status:	Race (**optional, mark all that apply**):		Ethnicity (**optional**):
◯ Citizen ◯ Non-Citizen ◯ Qualified Alien[1]	☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian	☐ Black ☐ White ☐ Other	☐ Hispanic ☐ Non-Hispanic

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

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines):	Does this child have a disability or have additional care needs?
◯ Yes, immunized ◯ No, in process ◯ No, non-medical exemption ◯ No, medical exemption ◯ Other:	◯ Yes ◯ No

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

Section 4 Cont'd: Child(ren)'s Information - Complete this section for every child in your home

***Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number (**Optional**):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to You:
		◯ Male ◯ Female	

Citizenship Status:	Race (**optional, mark all that apply**):		Ethnicity (**optional**):
◯ Citizen ◯ Non-Citizen ◯ Qualified Alien[1]	☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian	☐ Black ☐ White ☐ Other	☐ Hispanic ☐ Non-Hispanic

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

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines):	Does this child have a disability or have additional care needs?
◯ Yes, immunized ◯ No, in process ◯ No, non-medical exemption ◯ No, medical exemption ◯ Other:	◯ Yes ◯ No

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

Section 4 Cont'd: Child(ren)'s Information - Complete this section for every child in your home

***Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number (**Optional**):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to You:
		◯ Male ◯ Female	

Citizenship Status:	Race (**optional, mark all that apply**):		Ethnicity (**optional**):
◯ Citizen ◯ Non-Citizen ◯ Qualified Alien[1]	☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian	☐ Black ☐ White ☐ Other	☐ Hispanic ☐ Non-Hispanic

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

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines):	Does this child have a disability or have additional care needs?
◯ Yes, immunized ◯ No, in process ◯ No, non-medical exemption ◯ No, medical exemption ◯ Other:	◯ Yes ◯ No

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

Section 4 Cont'd: Child(ren)'s Information - Complete this section for every child in your home

***Please include all children in your home regardless of whether you are requesting care for them.**

Child Last Name:	Child First Name:	Child Middle Initial:

Social Security Number (**Optional**):	Date of Birth (MM/DD/YYYY):	Gender:	Relationship to You:
		◯ Male ◯ Female	

Citizenship Status:
- ◯ Citizen
- ◯ Non-Citizen
- ◯ Qualified Alien[1]

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

Ethnicity (optional):
- ☐ Hispanic
- ☐ Non-Hispanic

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

Immunization status (in accordance with Colorado Department of Public Health and Environment (CDPHE) guidelines):
- ◯ Yes, immunized
- ◯ No, in process
- ◯ No, non-medical exemption
- ◯ No, medical exemption
- ◯ Other:

Does this child have a disability or have additional care needs?
◯ Yes ◯ No

COPY THIS PAGE AS NEEDED FOR ADDITIONAL CHILDREN
Page _____ of _____

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

Section 5: Your Work/Self-Employment Income

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

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)
If NO, skip to Section 6.

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

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

Employer or Business Name	Employer or Business Address and Telephone Number	Work/Self-Employment Start Date	Self-Employed (or 1099)	Number of hours per week	How often paid?	Total earnings per pay period (including tips & ommissions) ***before taxes***
			◯ No ◯ Yes, as an **LLC** ◯ Yes, as an **S-Corp**			$
			◯ No ◯ Yes, as an **LLC** ◯ Yes, as an **S-Corp**			$

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

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

If YES, you're required to complete the following table: Please list all employment. (VERIFICATION IS REQUIRED.)
If NO, skip to Section 7.

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

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

Name of additional guardian/spouse

Employer or Business Name	Employer or Business Address and Telephone Number	Work/Self-Employment Start Date	Self-Employed (or 1099)	Number of hours per week	How Often Paid?	Total earnings per pay period (including tips & ommissions) ***before taxes***
			◯ No ◯ Yes, as an **LLC** ◯ Yes, as an **S-Corp**			$
			◯ No ◯ Yes, as an **LLC** ◯ Yes, as an **S-Corp**			$

Section 7: Court Ordered Child Support Paid Out

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

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

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

Section 8: Child Support Received and/or Ordered

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

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

Child Name(s)	Is child support received?	Is child support ordered?	Amount of Child Support Paid	How often paid?	How is it paid? (Venmo, cash, check, family support registry [FSR], etc.)	Name of non-custodial parent
	◯ Yes ◯ No	◯ Yes ◯ No	$			
	◯ Yes ◯ No	◯ Yes ◯ No	$			

Section 9a: Other Income

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

Scan the list of "other income types" below.

REQUIRED: Do you or any household members have other types of income? ◯ Yes ◯ No

If you don't see your income type included in the list below, write it in in the "other" spaces at the bottom.

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

Your Other Income:

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

Additional Guardian/Spouse's Other Income:

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

Child's Other Income
(Don't include child support covered in Section 8)

Child's Name:

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

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

Page _____ of _____

Section 9b: Assets (resources, belongings, valuables, etc.)

If your countable assets are worth more than $1,000,000 then you may not be eligible for CCCAP.

(REQUIRED): Do you or your additional guardian/spouse have any liquid resources?
Liquid resources are cash assets that may include (but are not limited to): cash on hand, money in checking or savings accounts, saving certificates, stocks or bonds, or nonrecurring lump sum payments, etc. ◯ Yes ◯ No

If NO, answer the next question about non-liquid resources.
If YES, you're required to provide the amount of your liquid resources in dollars $ _____

REQUIRED: Do you or your additional guardian/spouse have any non-liquid resources?
Non-liquid resources are non-cash assets that may include (but are not limited to): licensed/unlicensed automobile, RVs, real property, etc. ◯ Yes ◯ No

If NO, skip to Section 10.
If YES, you're required to provide the current dollar value of your non-liquid resources $

Section 10: Training/Education/Teen Parent Education Detail

Talk to your CCCAP specialist to learn about time limits on eligibility for CCCAP under this activity.

REQUIRED: Are you or your additional guardian/spouse participating in a training/education activity?
◯ Yes ◯ No

If YES, you're required to complete the following table: (VERIFICATION IS REQUIRED)
If NO, skip to Section 11.

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

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

Section 11: Substance Use Disorder Treatment Program Details

REQUIRED: Are you or an additional guardian/spouse participating in a substance use disorder treatment program? ◯ Yes ◯ No

If YES, you're required to complete the following table. If NO, skip to Section 12.

Individual Name:	Begin Date:
Treatment Facility Name:	Anticipated Completion Date (if known):

Treatment Type:

☐ Structured Outpatient (ASAM Level 2, Intensive Outpatient, IOP, ASAM Level 2.5, Partial Hospitalization, PHP, Day treatment)	☐ Highly structured residential (ASAM Level 3.5, clinically managed high-intensity residential services)
☐ Residential (ASAM Level 3.1, clinically managed low-intensity services, ASAM Level 3.3, clinically managed population-specific high intensity residential services, ASAM Level 3.2WM, withdrawal management - residential)	☐ Highly structured residential services with medical staff onsite (ASAM Level 3.7, inpatient, medically monitored intensive inpatient services, ASAM Level 3.7WM, withdrawal management with medical staff onsite)

Treatment Facility Address:

Street: State:
City: Phone Number:
Zip Code:

Hours per week:

☐ 6+, no overnight care
☐ 9+, no overnight care
☐ 24/7 residential care, including overnight

Individual Name:	Begin Date:
Treatment Facility Name:	Anticipated Completion Date (if known):

Treatment Type:

☐ Structured Outpatient (ASAM Level 2, Intensive Outpatient, IOP, ASAM Level 2.5, Partial Hospitalization, PHP, Day treatment)	☐ Highly structured residential (ASAM Level 3.5, clinically managed high-intensity residential services)
☐ Residential (ASAM Level 3.1, clinically managed low-intensity services, ASAM Level 3.3, clinically managed population-specific high intensity residential services, ASAM Level 3.2WM, withdrawal management - residential)	☐ Highly structured residential services with medical staff onsite (ASAM Level 3.7, inpatient, medically monitored intensive inpatient services, ASAM Level 3.7WM, withdrawal management with medical staff onsite)

Treatment Facility Address:

Street: State:
City: Phone Number:
Zip Code:

Hours per week:

☐ 6+, no overnight care
☐ 9+, no overnight care
☐ 24/7 residential care, including overnight

Section 12: Disability Detail

REQUIRED: Are you or an additional guardian/spouse disabled? ◯ Yes ◯ No

If YES, you're required to complete the following table: (VERIFICATION IS REQUIRED)
If NO, skip to Section 13.

Name:		Begin Date:
Disability Type: ☐ Permanent ☐ Temporary; Anticipated End Date:	Is this individual able to take care of the child(ren)? ◯ Yes ◯ No	Physician Review Due Date **(if applicable):**
Name:		Begin Date:
Disability Type: ☐ Permanent ☐ Temporary; Anticipated End Date:	Is this individual able to take care of the child(ren)? ◯ Yes ◯ No	Physician Review Due Date **(if applicable):**

Section 13: Employment/Training/School/Job Search Schedule

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

Example:	*Mon. 8:00a - 5:00p*	*Tues. 8:00a - 5:00p*	*Wed. 8:00a - 5:00p*	*Thurs. 8:00a - 3:00p*	*Fri. 8:00a - 5:00p*	*Sat. 8:00a - 12:00p*	*Sun. 8 a.m.- 5 p.m.*
YOUR SCHEDULE:	Monday	Tuesday	Wed.	Thursday	Friday	Saturday	Sunday
Work/Job Search							
Training/School							
Substance Use Disorder Treatment Program							

ADDITIONAL GUARDIAN/SPOUSE SCHEDULE:	Monday	Tuesday	Wed.	Thursday	Friday	Saturday	Sunday
Work/Job Search							
Training/School							
Substance Use Disorder Treatment Program							

If your schedule varies please explain:

Section 14: Children's Current Care Schedule (REQUIRED)

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

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

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

Is this child enrolled in a Head Start/Early Head Start Program? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Is this child enrolled in the Universal Preschool Program? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

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

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

Is this child enrolled in a **Head Start/Early Head Start Program**? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Is this child enrolled in the **Universal Preschool Program**? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

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

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

Is this child enrolled in a Head Start/Early Head Start Program? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Is this child enrolled in the Universal Preschool Program? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

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

Is this a new provider? (REQUIRED) ◯ Yes ◯ No

If yes, has the child's enrollment been confirmed with the provider? (REQUIRED) ◯ Yes ◯ No

If yes, you're required to provide an anticipated Start Date:

Is this child enrolled in a **Head Start/Early Head Start Program**? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Is this child enrolled in the **Universal Preschool Program**? ◯ Yes ◯ No

If yes, what is their enrollment start date and end date? Start: End:

Notice and Acknowledgement of Data Sharing

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

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

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

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

LOW-INCOME CHILD CARE CLIENT RESPONSIBILITIES AGREEMENT

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

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

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

1. If myself or any teen parent or additional guardian/spouse in my child care case is self-employed I/we must maintain an average income that exceeds business expenses and I agree to track and verify income, expenses, work schedule and need for care to assist in my eligibility determination.
2. If child care is provided for an employment or self-employment activity then the taxable gross wages divided by the number of hours worked must equal at least the current federal minimum wage in order to continue receiving child care. If a self-employment endeavor is less than twelve (12) months old and I am not making minimum wage, I will communicate this to my child care worker so

that I may utilize the Self-Employment Launch Period.

3. My parent fee is based on countable household income, household size and number of children in care and is subject to change. I will be notified of my new parent fee at the time of application or re-determination; or, when a reduction/increase of household parent fee occurs.
4. If I do not pay my parent fee or make acceptable payment arrangements with my child care provider, I will lose my child care benefits at re-determination and will not be able to receive child care assistance with another child care provider and/or through any other county.
5. If myself or an additional guardian/spouse in my child care case is found to have intentionally given false information by deed or omission, my child care household cannot get child care assistance for twelve (12) months for the first offense, twenty-four (24) months for the second offense, and permanently for the third offense. This crime is subject to prosecution under federal and state laws.

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

Your signature:

Date:

Signature of Additional Guardian/Spouse:

Date:

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

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

Email: ocrmail@hhs.gov

Keep this page for your reference

Revised 7/31/2026

CCCAP Eligibility Information.

1. **Are you presently receiving Colorado Works/TANF?**
   If yes, you must request Child Care Assistance through your technician in that program.

2. **Are you presently receiving Child Care Assistance?**
   If yes, you must contact your current Child Care Technician.

To be eligible for Low Income CCCAP, you must be in an eligible activity. Employment, being a teen in high school/GED, job searching and school/college are eligible activities. If yours is a 2-adult family, both adults must be in an eligible activity or one adult incapacitated and cannot care for the child/ren (medical verification will be required). In addition, the total family gross income must be under the maximum income guidelines for the family size as listed below.

3. **You are within the required income guidelines to receive childcare subsidies if your family's TOTAL Monthly Gross Income is within the maximum defined below:**

Number of Persons In Family	Maximum Gross Monthly Income	Effective. 7/31/2026
2	$ 3,260.63	
3	$ 4,108.54	**To calculate income:**
4	$ 4,956.46	Example
5	$ 5,804.38	Weekly Gross X 4.33 =
6	$ 6,652.29	**Total Monthly Gross Income**
7	$ 7,500.21	
8	$ 8,348.13	
9	$ 9,196.04	

5. **Are the children who will use childcare under the age of 13?**
   If so, the children needing childcare are within the age guidelines for childcare subsidies. Children who are 13 or over but under the age of 19 and meet the "special needs" criteria, have written verification from a physician/other appropriate professional and from the childcare provider, may be eligible.

6. **Is the Child Care Assistance for Job Searching?**
   Job Search at application is an eligible activity in El Paso County. If eligible you will be authorized for up to 13 weeks of job search. After exhausting job search time, you must be in an eligible activity of employment, paid training, school/college, or teen parent in high school/GED to remain eligible for CCCAP.

7. **Is the Child Care Assistance for Adult GED, job training or post-secondary education?**
   You may receive up to 104 weeks of childcare benefits while in an accredited college (Bachelors degree or less) or accredited job skills training program. You may also receive up to 52 weeks of child care benefits while in an adult GED, high school diploma, English as a Second Language or other basic skills program

8. **Are you the biological parent, a legally established guardian, a blood or adoptive relative, or unrelated individual who is taking the place of a parent and need childcare for a child/ren?**
   An unrelated individual who is taking the place of a parent must obtain an affidavit from the child's biological parent or legal guardian which identifies the unrelated individual as the child's primary caretaker.

Verification needed – specifically defined:

1. **Earned Income. 1.** Verify the last thirty (30) days of income by copies of check stubs, wage printout, or written verification from employer. If, the prior thirty (30) day period does not provide an accurate indication of anticipated income, a county can require evidence of up to twelve (12) of the most recent months of income. An adult caretaker may also provide evidence of up to twelve (12) of the most recent months of income if they choose to do so if such evidence more accurately reflects the adult caretaker's current income level. **2.** In addition, have your employer complete and sign the Request for Employment and Earnings Verification Letter (includes work schedule, how often paid etc)
2. **Unearned Income.** Verify in writing any unearned income, such as child support, Social Security, Workmen's Compensation, Unemployment Benefits, pensions and annuities, educational loans and grants, financial awards letter, military benefits etc.
3. **Self-employment income**. **1.** Net income from self-employment (copies of gross receipts minus operating expenses for the prior 30 days, ongoing balance sheets or ledgers showing totals for income and expenses for prior 30 days from one's own business, professional enterprise, or partnership). Expenses include costs of goods purchased, rent & utilities (business), upkeep of necessary equipment, business taxes (not personal tax). If, the prior thirty (30) day period does not provide an accurate indication of anticipated income, a county can require evidence of up to twelve (12) of the most recent months of income. An adult caretaker may also provide evidence of up to twelve (12) of the most recent months of income if they choose to do so if such evidence more accurately reflects the adult caretaker's current income level. **2.** You must also verify your work schedule and must be making at least minimum wage.
4. **Proof of Residency/Address in El Paso County –** lease, mortgage statement, utility bill, paycheck stub etc.
5. **School/College verification**. School verification form, class schedule with days/times, financial aid award letter, Veterans/GI bill verification
6. **Teen Parent.** A teen parent is someone under 19 years of age, or under 21 years of age if attending high school, GED program, or junior/middle school.
7. **Child Care Provider:** If you need help finding a provider please visit www.coloradoshines.com or call 1-877-338-2273 for an individualized referral.
8. **Identification and Citizenship:** Picture ID is required from the applicant/parent. Proof of citizenship or legal alien status of the children requesting care is also required.

IMPORTANT

You are personally responsible for the cost of childcare until you are approved. If approved, you and your childcare provider will receive written authorization from CCCAP. If you cannot afford to privately pay your provider, please make alternate arrangements for childcare until you have been approved.

Questions about your CCCAP application?

CCCAP Staff are available by telephone from 8am to 4:30pm. M-F at 719-444-8178.

Where do I turn in my verifications?

Verifications can be faxed to 719-444-8108, emailed to DHSCCCAPinbox@elpasoco.com (This is a non-reply email address), mailed to or dropped off at our office located at 1675 W Garden of the Gods Rd. Colorado Springs, CO 80907

EPC-AP-ADC-4 (Rev: 09-2014)

Request for Employment and Earnings Verification

For Office Use Only:	From: **El Paso County**
Case Name_____	**Department of Human Services**
Case Number _____	**P.O. Box 2692**
Technician (Case Manager) _____	**Colorado Springs, CO 80901**
	719-444-8108 FAX
	DHSCCCAPinbox@elpasoco.com

RELEASE

I give my permission for (employer)_____
to release this information to El Paso County Department of Human Services.

Signature: _____ Date: _____

Employee Name (Print):_____ Social Security No. _____

Place of Employment:_____

Job Title:_____

Address:_____

Telephone Number:_____

Effective Date of Employment:_____

Pay Periods *(Mark one)*

____ Once a month ___ Once a week
____ Every two weeks ___ Twice a month

Day of week paid: _____
Rate of hourly pay: $_____
Hours worked per week: _____
Date of first check: _____
Is health insurance available? ❒ yes ❒ no
Is paid sick/vacation available? ❒ yes ❒ no

Work Schedule

Please be specific and state ALL possible shifts and/or hours and days:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

❒ Please provide wage information for the period specified on the back. Payroll records are also acceptable.

❒ If **NOT** currently employed by your firm:

Date of termination:_____

Reason for termination: _____

Date of final pay: _____

Gross amount of final pay: $_____

Please complete and return this form in 5 days. Thank you for your cooperation.

Signature of employer/representative _____

Please print name of employer/representative _____

Title _____ Phone _____ Date _____

Please provide wages **paid** during the following period

_____ through _____

Indicate in the last column any separate pay for: ____Vacation
____ Bonus
____
____ Tips
____ Earned Income Credit

Pay Period					
Pay Date	Beginning	Ending	Gross Amount	Hours	*Other Pay

Please indicate if there are any non-taxable benefits such as a 401K Retirement being deducted.

_____ Yes Amount per month $_____ _____ No

"Eligibility Check List"
Colorado Child Care Assistance Program (Low Income)

This form will tell you what documents are necessary to determine your eligibility for CCCAP (Low Income category of childcare assistance). Please submit these verifications right away, but no later than sixty (60) days after the application date.

Failure to turn in the necessary information may result in the denial of your application.

Required Verification

The following information is **required** for your CCCAP application to be processed:

_____ **1. Earned Income**

A. Verify the last thirty (30) days of income by copies of check stubs, wage printout, or written verification from employer.

If the prior thirty (30) day period does not provide an accurate indication of anticipated income, a county can require evidence of up to twelve (12) of the most recent months of income. An adult caretaker may also provide evidence of up to twelve (12) of the most recent months of income if they choose to do so if such evidence more accurately reflects the adult caretaker's current income level.

B. In addition, you must have the provided employment verification letter completed and **signed by your employer.**

C. Self-employed: Profit & Loss statements; balance sheets or ledgers showing ongoing totals for income and expenses; copies of all receipts for all income & expenses; number of hours worked each week and work schedule (days/times).

_____ **2. Employer verified Work Schedule (if needing care outside of M-F 6a-6p)**

The employer may include the work schedule on the provided employment verification letter. This must include days and times of availability if schedule varies.

_____ **3. Unearned Income**

Examples: Child Support, Worker's Compensation, Unemployment Benefits, Social Security Survivor and Disability benefits, VA benefits, GI bill monies etc. Verification includes award letters, check stubs etc.

_____ **4. School/College**

Completed School/College letter with expected grad date; Class Schedule (days & times); Financial Aid Award letter; proof of military monies for education (GI Bill etc); Employer signed Work-Study letter with work schedule

_____ **5. Child Care Provider**

Name of Child Care Provider with whom **you have verified enrollment** and started paperwork. If provider is a friend or relative who is not licensed and contracted with El Paso County, complete and return "Selection of qualified unlicensed provider" form. This form must be requested from CCCAP.

_____ **6. CCCAP Application**

Complete **all** sections/pages of the application, complete page 3 for each child or 2nd adult in the home (copies may be needed) and sign all 3 signature areas of the application.

_____ **7. Identification**

Photo I.D. for self, spouse, caretaker relative, guardian and any other adult caretaker in the household.

_____ **8. Citizenship/Legal Alien Status**

Verification of **citizenship or legal alien status** is required for children**.** This is usually a birth certificate.

_____ **9. Proof of Residency/Address**

Proof of your address may be a lease, mortgage statement, current utility bill, voter registration card, vehicle registration, current paycheck with address, etc.

_____ **10. Proof of Shared Custody Schedule (if applicable)** Divorce, court papers etc.

Applications have a 15-day processing timeframe from the date of county receipt. Check your email and mailbox regarding your status.

Questions about your CCCAP application?

CCCAP Staff are available by telephone from 8am to 4pm M-F at 444-8178.

Where do I turn in my verifications?

Verifications can be faxed to 444-8108, emailed to DHSCCCAPinbox@elpasoco.com (this is a non-reply email address), mailed to or dropped off at our office located at 1675 W Garden of the Gods Rd. Colorado Springs, CO 80907

CHILD CARE PROVIDER INFORMATION

Provider Name: _____ Provider's License ID #: _____

Address: _____ Telephone: _____

Start date of care: _____

CHILD INFORMATION

Child Name	Age	*What days of the week is your child in need of care? * Do they need Full time care (MORE than 5 hrs. per day) or Part time care (LESS than 5 hrs. per day)? *Is care needed for days, nights and/or weekends? **Example:** **Mon-Fri FT Days**	*What grade is the child in? *½ day or full day Kindergarten (if school aged)	Name of school & school district # (if school aged)

Is care needed for before and/or after school? _____Yes _____No

Is care needed for days school is closed? _____Yes _____ No

Will provider transport your child/children to school or to another provider? _____ Yes _____ No

PARENT/GUARDIAN INFORMATION

Parent Name: _____ Parent signature_____

Date _____ Case Number _____

DEPARTMENT OF HUMAN SERVICES
STACIE KWITEK-RUSSELL, EXECUTIVE DIRECTOR

Name of School/College: _____

Address: _____

Telephone Number: _____

School is Accredited by: _____

Effective Date of Enrollment: _____

The following information is needed to verify that **(print name of student):** _____ is eligible for Day Care Services. Please be as specific as possible. **SS#:** _____

1. Does student already hold a college degree? _____
   If yes, type and from what college? _____
2. Course of Study: _____
3. ***Anticipated* Graduation Date** (month/year): _____
4. **State specific job skills** that will be obtained. _____
5. Upon completion, the student will receive: (Circle one)

   Associates Degree Bachelor's Degree Certificate High School Diploma
   GED Master's Degree Other _____

_____ _____ _____
Signature of Academic Advisor Title Date

_____
Please Print Name of Academic Advisor

RELEASE

I give my permission for (school) _____ to release this information to El Paso County Department of Human Services.

Signature: _____ Date: _____

Client must attach:
1) Financial Aid Award Letter
2) Official class schedule for *current* semester
3) Verification of Work Study Hours (if applicable)
4) Satisfactory progress reports at the end of each semester.

*++ Verifications must be submitted **before** the beginning of **each** semester. ++*

For Office Use Only

Case Number: _____ Worker: _____

EPC-SVS-DC-12 CCCAP (Rev. 11/29/2022)

Voter Registration Choice Form

For office use only

Date: _____

The applicant completed a voter registration form

☐ Yes ☐ No

The applicant requested and was given a voter registration form for later delivery

☐ Yes ☐ No

Employee Initials: _____

Instructions

Please read the following information and complete and sign the form below. This agency will keep the form for its records.

Important Notice

You may file a complaint with the Colorado Secretary of State if you believe that someone has interfered with your right to:

- register or decline to register to vote,
- privacy in deciding whether to register or in applying to register to vote, or
- choose your own political party or other political preference.

Send complaints to:

Colorado Secretary of State
1700 Broadway
Denver, CO 80290
Phone: (303) 894-2200

You may apply to register to vote or update your current registration today

- If you are not registered to vote where you live now, you may apply to register to vote here today.
- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

Does filling out or not filling out the registration form affect services I am applying for?

No. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

How private is this process?

The name and location of the agency or public office where you received the voter registration application will not appear on your records. If you decide not to use this application to register to vote, that is also confidential.

Complete and sign below

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Please check only one of the following boxes. *If you do not check either box, you will be considered to have decided not to register to vote at this time.*

☐ Yes, I want to apply to register to vote today. (Please fill out the Voter Registration Form)

You are eligible to register to vote if you:

- Are a United States citizen.
- Are or will be a resident of the state of Colorado for at least 22 days immediately before an election in which you intend to vote,
- Are at least 16 years of age but you must be 18 years of age or older on the date of an election in which you intend to vote,
- Are NOT serving a sentence for a felony conviction.

☐ No, I do not want to apply to register to vote today.

_____
Your full name (please print)

_____ _____
Signature Today's date (MM/DD/YY)

Colorado Voter Registration Form

Fill out all fields marked with an asterisk (*)

Eligibility

1 * Are you a citizen of the United States? ☐ Yes ☐ No **If you answered "No", do not complete this form.**

Name

2

_____ * Last Name | _____ * First Name | _____ Middle Name | _____ Suffix

Identification

Provide your birth date and your identification information.

3

Remember to write your birth date below.

___ - ___ - ___

*MM *DD *YYYY

☐ I have a valid CO Driver's License or ID card.
Write that number here: ___ ___ - ___ ___ ___ - ___ ___ ___ ___

☐ I do not have a CO Driver's License or ID card.
Write the last four digits of your SSN here: X X X - X X - ___ ___ ___ ___

☐ I do not have a Colorado Driver's License, ID card, or a Social Security Number.

The address where you live

4

_____ * Address (no P.O. Boxes) | _____ Unit Number | _____ * City or Town

CO

_____ State | _____ * Zip Code | _____ Colorado County

☐ I am homeless. This is a location I regularly return to. I have also provided a mailing address in Section 5.

The address where you receive mail

5

☐ Same as above

_____ Address

_____ City or Town | _____ State | _____ Zip Code

The address to mail your ballot

The County will mail your ballot here until you say otherwise.

6

☐ Same as above

_____ Address

_____ City or Town | _____ State | _____ Zip Code

Political affiliation

Choose only **7a** or **7b**

7a or 7b

I would like to be a member of the following political party:

☐ American Constitution ☐ Approval Voting ☐ Center ☐ Democratic ☐ Green ☐ Libertarian ☐ No Labels ☐ Republican ☐ Unity

_____

☐ I would like to be unaffiliated

Updating a current record?

If so, you must provide the applicable changes here.

8

☐ I am not updating a current record ☐ I am no longer overseas ☐ I am no longer absent from Colorado due to military service

_____ Previous home address | _____ Previous legal name

_____ Previous mailing address | _____ Previous party affiliation

Declaration

9

Warning: It is a Class 1 misdemeanor to swear or affirm falsely as to your qualifications to register to vote.

Self-Affirmation: I affirm that I am a citizen of the United States; I have been a resident of Colorado for at least twenty-two days immediately before an election I intend to vote in; I am at least sixteen years old; and I understand that I must be at least eighteen to be eligible to vote in any election. I further affirm that the residence address I provided is my sole legal place of residence. I certify under penalty of perjury that the information I have provided on this application is true to the best of my knowledge and belief; and that I have not, nor will I, cast more than one ballot in any election.

_____ * Signature or mark | _____ * Date | _____ Witness Signature | _____ Date

If you are unable to sign, you must make a mark and have the mark witnessed by another person.

Optional information

10

_____ Phone number with area code

I want to receive election information by email: _____ Email address
(You will not receive a ballot by email)

☐ I would like to be an election judge

Gender Identity (*select one*): ☐ Female ☐ Male ☐ X ☐ Not Disclosed

Information about this registration

How do I turn in this form?

Sign the form. Then mail, deliver, or scan the signed form and email it to your county clerk and recorder. You may find a list with contact information at www.govotecolorado.gov.

You may also mail it to:

Colorado Department of State
Elections Division
1700 Broadway, Suite 550
Denver, CO 80290

Am I eligible to register to vote?

You are eligible to register to vote if you:

- Are a United States citizen
- Are 16 years old, but you must be at least 18 to vote in an election
- Are a Colorado resident for at least 22 days immediately before the election you intend to vote in
- Are not currently serving a term of imprisonment for a felony conviction

If I don't know my Colorado driver's license or Colorado ID card number may I provide my Social Security Number instead?

No. If you have a Colorado Driver's License or ID card issued by the Colorado Department of Revenue, you must provide that number.

If I don't have a Colorado driver's license, Colorado ID card, or social security number, may I still register to vote?

Yes. An applicant who is qualified to vote in this state but does not have a driver's license, state-issued identification card, or social security number may still register to vote. In such cases, the person may be required to provide an acceptable form of identification. A list of acceptable forms of identification can be found at www.govotecolorado.gov.

How will I know if my registration was processed?

If you are registering to vote for the first time in the state of Colorado, your application will be processed within 2 weeks. Approximately 20 days after your county clerk and recorder receives your registration form, you will receive an official information card by mail.

If you are using this form to update an existing Colorado voter registration, you can check your status by visiting www.govotecolorado.gov and clicking on "Find My Registration".

If you are pre-registering to vote, you will receive an official information card by mail and may check your status once you become eligible to vote.

Other frequently asked questions about registering and voting

Will I need identification to vote?

If you vote in person, yes. If you are voting by mail for the first time, you may need to provide a photocopy of your ID.

A complete list of acceptable forms of identification can be found at www.govotecolorado.gov.

How do I get a mail ballot?

If you register to vote at least eight days before an election conducted by your county clerk and recorder, the clerk will automatically mail you a ballot. If you register after the eighth day before Election Day, you must visit one of the Voter Service and Polling Centers in your county to get a ballot.

May I register to vote if I was arrested for or convicted of a crime?

Yes, if you

- Are on probation for either a misdemeanor or felony;
- Are a pretrial detainee awaiting trial;
- Are currently in jail serving a misdemeanor sentence only; OR
- Are no longer serving a term of imprisonment due to a felony conviction.

If you were previously registered and were incarcerated due to a felony conviction, that registration will have been canceled and you must re-register if you wish to vote.

What information will I receive by email?

By choosing to receive election information by email, you may receive information about upcoming election activities and other election correspondence by email from your county clerk and recorder. But ballots and some mailings will still be sent by regular mail. Under Colorado law, your email address is protected. It will not be shared with anyone.

Will my information be publicly available?

Some of the information you provide on this form is public information as required by law. Your social security number, driver's license number, month and day of birth, signature, and email are confidential. You may be eligible to keep more of your voter information private. For details contact your county clerk and recorder.

Who should I contact if I have more questions?

Contact your county clerk and recorder. You can find a list with contact information at www.govotecolorado.gov.

You may also contact the Secretary of State's office

Phone: 303-894-2200
Fax: 303-869-4861
Email: State.ElectionDivision@coloradosos.gov

Information for unaffiliated voters

I am registered as unaffiliated. Will I be able to vote in the primary election?

Yes. Unaffiliated voters are eligible to vote in the primary election, but you may only vote one party's ballot.

Can I participate in a party's caucus meeting if I am unaffiliated?

No. To participate in a party caucus meeting you must join that party before the party's caucus. However, you are still eligible to vote in any participating party's primary election.