

**COLORADO DEPARTMENT OF HUMAN SERVICES
CHILD CARE ASSISTANCE PROGRAM**

REDETERMINATION OF ELIGIBILITY FORM

We are sending you this form so that we can update your eligibility for child care assistance through the County Department of Human Services. Your answers to the questions on this form will provide us with the information we need to continue your child care assistance. Please note that failure to complete this form and supply required documentation will result in the discontinuance of your child care benefits.

You MUST answer all questions, sign and date this form.

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

Client Name: _____ **Household No:** _____
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

EMPLOYMENT (include the last three months pay stubs for verification)

First Parent's Name _____

1a. Are you working?

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

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

1b. Do you have a second job?

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

___ no

2. 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

3. Are there two parents in your home? (Do not include your parents)

_____ yes _____ no **If yes, answer question 3a**

3a. Second Parent's name _____

Is the second parent working?

___ yes If yes, where? _____ Phone _____

___ no If no, what is the second parent's activity? _____

TRAINING/SCHOOL

First Parent Name: _____

1. _____ yes _____ no Are you in training? Where? _____
 _____ yes _____ no Are you in school? Where? _____

2. _____ yes _____ no Are there two parents in your home? **If yes, answer question 2a.**

Second Parent Name: _____

2a. _____ yes _____ no Are you in training? Where? _____
 _____ yes _____ no Are you in school? Where? _____

HOUSEHOLD INFORMATION

List ALL people in your household:

Last Name, First Name, Middle Initial	How related to you?	Sex 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? If yes, complete the following information:

Newly added adults (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/OtherPacific Islander, , W-White

Marital Status Codes: D-Divorced, M-Married, S-Single, P-Separated, W-Widowed

Newly added dependents/children

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)	Special needs child? (Y/N)	Date of Birth	Immunization information: (codes below)
1.								
1a. Name of Parent(s) outside of household who may have duty to support: First: _____ Last: _____								
2.								
2a. Name of Parent(s) outside of household who may have duty to support: First: _____ Last: _____								
3.								
3a. Name of Parent(s) outside of household who may have duty to support: First: _____ Last: _____								

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**

Name	Date left	Reason for Leaving

EMPLOYMENT OR TRAINING/SCHOOL SCHEDULE

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

<i>EXAMPLE</i>	<i>Mon.</i> 8:00-5:00	<i>Tues.</i> 8:00-3:00	<i>Weds.</i> 8:00-5:00	<i>Thurs.</i> 8:00-3:00	<i>Fri.</i> 8:00-5:00	<i>Sat.</i> 0	<i>Sun.</i> 0
MY SCHEDULE	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Work							
Training/School							
2ND PARENT	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Work							
Training/School							

Comments: _____

CHILDREN'S SCHEDULE

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

Child Name	Child In School	School of Attendance and grade	Child Care Provider (list for EACH provider)							
			Mon <i>Exact hours in care</i>	Tues. <i>Exact hours in care</i>	Wed. <i>Exact hours in care</i>	Thurs <i>Exact hours in care</i>	Fri. <i>Exact hours in care</i>	Sat. <i>Exact hours in care</i>	Sun. <i>Exact hours in care</i>	
	Yes No									
	Yes No									
	Yes No									
	Yes No									
	Yes No									
	Yes No									
	Yes No									
	Yes No									
	Yes No									

Comments: _____

INCOME QUESTIONS: List ALL income. If no income enter a zero.

Fill in your total family income per month:

	My Income	2nd Parent Income		My Income	2nd Parent 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	\$ _____	\$ _____	Lease bonuses & royalties	\$ _____	\$ _____
Alimony Payment	\$ _____	\$ _____	Military allotments	\$ _____	\$ _____
Unemployment insurance	\$ _____	\$ _____	Strike benefits	\$ _____	\$ _____
Worker's compensation	\$ _____	\$ _____	TANF or Colorado Works	\$ _____	\$ _____
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 UNEARNED INCOME

OTHER INCOME Do you or anyone in your household receive any of the following incomes? If yes, please complete the table below.

1. Housing voucher or cash assistance Yes No
2. Colorado Works/ TANF cash assistance Yes No

3. Food stamp assistance Yes No
 No but I would like to apply
4. Supplemental Security Income (SSI) Yes No

5. Refugee cash assistance or medical assistance Yes No
6. Old age pension Yes No
7. Low-income energy assistance (LEAP) 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	Relation	Phone

OTHER CHANGES OR COMMENTS YOU WANT TO MAKE:

Authorization to Supply Information

I hereby authorize the _____ County Department of Social Services, in the course of administering the social services program, to supply information obtained directly from me, or from any other person, agency, or institution which has provided information to the county department with my written consent, to the following:

The county department is authorized to release information to the following:

Any child care provider I may choose to use, any employer for whom I work, and/or any school or training institution I may be attending.

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

Authorization to Release Information

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

- Any child care provider I may choose to use,
- Any employer for whom I work,
- Any documentation submitted for self-employment,
- Any school or training institution I may be attending, and
- Any other information that may be pertinent, including housing.

Signature of Client: _____ Date: _____

RIGHT OF APPEAL AND FAIR HEARING

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

- ◆ If your child care benefits are **denied**, you must call your child care assistance worker within 20 days of the date of 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 20 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.

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

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

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

1. Write a letter to: **Division of Administrative Hearings**
633-17th St, 13th Floor
Denver, CO 80202
2. You must get the letter in the mail not later than 15 days after the county hearing decision has been made.
3. In the letter you need to say that you want to appeal the county hearing decision and why you want to appeal the decision. If you need help doing this you can ask anyone you desire to help you, or talk to a legal aid office, or ask your County Social Services people to help you.
4. When your letter is received, you will get a letter from the Office of Appeals explaining what will be done and the date for the appeal hearing. It will also explain who can come with you, who can present testimony and other information about the hearing.

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

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:

The Secretary of Health and Human Services
370 L'Enfant Promenade, S.W.
Washington, DC 20447

Recipient's Copy of Right of Appeal is Page 8.

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