



CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

Office Use Only

SUPPLEMENTAL PAYMENT REQUEST

Submit this form to the child care assistance office serving the family's community, when additional care the family was eligible for was provided, and was not included in the family's Child Care Assistance Authorization document.

Family Name: Family ICCIS ID Number:

Supplemental Payment requested for Month and Year (MM/YYYY):

Child Care Provider/Facility Name:

Child Care Provider/Facility ICCIS ID Number:

1. First and Last Name of Child:

Total unit of care that should have been authorized:

Reason for Additional Care Requested:

(For CCA Use Only) Payment amount verified:

(For CCA Use Only) Supplemental payment amount:

2. First and Last Name of Child:

Total unit of care that should have been authorized:

Reason for additional care requested:

(For CCA Use Only) Payment amount verified:

(For CCA Use Only) Supplemental payment amount:

3. First and Last Name of Child:

Total unit of care that should have been authorized:

Reason for additional care requested:

(For CCA Use Only) Payment amount verified:

(For CCA Use Only) Supplemental payment amount:

Requestor's Agency Name

Requestor's Printed Name

Requestor's Direct Phone Number

Requestor's Signature

Date

The Supervisor of the child care assistance office serving the family's community must approve the request prior to the request being processed for additional payment.

Approved

Denied. Explain reason for denial: \_\_\_\_\_

\_\_\_\_\_  
Designee Agency Name

\_\_\_\_\_  
Designee Supervisor's Printed Name

\_\_\_\_\_  
Direct Phone Number

\_\_\_\_\_  
Designee Supervisor's Signature

\_\_\_\_\_  
Date