



## Child Care Assistance Program Information and Application Checklist

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**Who do I contact if I need help filling out the application or have questions?** If you have questions or need assistance in completing your application, please contact your local child care assistance office based on the community where you reside. See listing on the third page of this program information and application checklist.

**Is an interview required?** Yes. An interview is required with the parent(s) of the family before it can be determined if you are eligible for assistance. Your interview may be in person or by telephone. Your application will be denied if you do not complete an interview.

**How much can I make and still qualify?** Financial eligibility is based on the total monthly gross income (earned and unearned) by family size. This also determines the family's contribution (co-pay). The most current income limits can be found on the *Family Income and Contribution Schedule* located on the Child Care Program Office website at: <http://dhss.alaska.gov/dpa/Pages/ccare>

**Will I have to pay anything?** Yes. You will have a monthly family contribution amount based on your income and family size. This is called a co-pay. The Child Care Assistance Program (CCAP) pays your provider directly based on the type of provider, age of the child(ren), and community in which services are provided. The *Child Care Assistance Program Rate Schedule* determines the amount the CCAP will pay your provider on your behalf, minus your co-pay. Your provider may also charge more than the CCAP pays. Each month you will have to pay your provider the co-pay amount and the difference, if any, between what the provider charges and what the CCAP pays. The most current *Child Care Assistance Program Rate Schedule* can be found **on the Child Care Program Office website at:**  
<http://dhss.alaska.gov/dpa/Pages/ccare>

**Who is considered part of my family? The following descriptions of family are for Child Care Assistance Program purposes only:**

- To be considered part of your family, ***all members must live in the same home***, except:
  - If one parent of any of the children in common with you, is away from the family home due to participating in an eligible activity and the home is still their residence, they are part of your family;
  - Married parents who are living apart are considered part of your family if the parent who is not living in the family home retains the home as their residence, or intends to return to the family home.
- Of the people living in your home, your family includes: ***yourself, your spouse and each of your children who are under 18 years of age.***
- You may also have children living in your home who are not biologically yours. ***If you are their guardian and have financial responsibility for them***, they are counted as part of your family.
- If you are not married, but ***the other parent of any of your children lives in your home***, he or she and his or her children are considered part of your family.
- If you are not married but are living in the same home with another adult who has children of their own, and you have no children in common, he or she and his or her children are not considered part of your family. In this case each parent may apply to receive child care assistance for their own children.



✓ Check to be sure you have attached the identified documents on the previous page. To reduce processing time and avoid delays please be sure all applicable items are submitted and received by the local child care assistance office with the completed application. **Keep a copy of the entire application and checklist for your records.**

**Submit the completed application with all supporting documents to the local child care assistance office serving the community in which you reside or are conducting your eligible activity:**

<p>Serving families within the Municipality of Anchorage:</p> <p><b>Alaska Family Services Inc.</b>          1251 Muldoon Rd, Ste 157          Anchorage, AK 99504          Phone: (907) 644-5000          Fax: (907) 644-5020          Email: <a href="mailto:ccaanc@akafs.org">ccaanc@akafs.org</a></p> <p>Serving families in the communities including: Cordova, Palmer, Valdez, Wasilla and Willow:</p> <p><b>Alaska Family Services Inc.</b>          899 W Commercial Drive          Wasilla, AK 99654          Phone: (907) 373-4450          Toll-free: 1-866-746-4080          Fax: (907) 373-4468          Toll-free: 1-888-415-6868          Email: <a href="mailto:centralcca@akafs.org">centralcca@akafs.org</a></p> <p>Serving families in the communities including: Aleutian Chain, Bristol Bay Area, Kenai Peninsula, Kodiak, Kotzebue and Nome:</p> <p><b>The LeeShore Center</b>          601 Frontage Rd., Ste 204          Kenai, AK 99611          Phone: (907) 283-4707          Toll-free: 1-877-855-2227          Fax: (907) 283-4681          Toll-free: 1-877-855-2230          Email: <a href="mailto:coastalccap@alaska.net">coastalccap@alaska.net</a></p>	<p>Serving families in the communities in northern and southeast Alaska including: Angoon, Barrow, Craig, Eielson AFB, Fairbanks, Gustavus, Haines, Hoonah, Juneau, Ketchikan, Metlakatla, Moose Creek, North Pole, North Slope, Petersburg, Prince of Wales, Salcha, Sitka, Skagway, Tok, Wrangell, Yakutat, and Y-K Delta area:</p> <p><b>thread</b>          1949 Gillam Way, Ste G          Fairbanks, AK 99701          Phone: (907) 479-2212          Toll-free: 1-855-479-2212          Fax: (907) 479-2295          Toll-free: 1-855-479-2295          Email: <a href="mailto:thread@thrivalaska.com">thread@thrivalaska.com</a></p>
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## **Your Rights and Responsibilities**

**The following information is based on State Regulations 7 AAC 41 – Child Care Assistance Program. These regulations as well as the Child Care Assistance Program Policies and Procedures are available on the Child Care Program Office website at: <http://dhss.alaska.gov/dpa/Pages/ccare>.**

### **Your Responsibilities**

Applying families must provide complete, accurate, and current information and required verification regarding children, family income, hours of employment or training, work activities, and other factors that affect eligibility for program benefits. If requested, a family shall provide documentation to support information provided on the application.

**When do benefits begin if I am determined eligible?** If eligible, your certification period will begin the date your acceptable application was received by the child care assistance office, as long as all the required documentation is received within 30 days. Applications that are not legible, and/or do not include at least your name and signature on the Statement of Truth, Rights and Responsibilities and Authorization for Release of Information page will not be accepted or processed.

**Which child care provider(s) can I use?** Child care providers must also apply to participate in the Child Care Assistance Program (CCAP). A provider cannot receive State funding until they are approved or licensed. The Child Care Resource and Referral agency that serves your community can provide you with a list of participating providers in your area. Visit [www.threadalaska.org](http://www.threadalaska.org) for more information.

### **Participating families are required to:**

- Select an eligible child care provider;
- Pay your child care provider each month, your monthly contribution (co-pay) AND the difference between what your provider charges and what the CCAP pays on your behalf as long as an authorization for care was issued for your Child Care Assistance family and care was used during the month, even if you did not sign a contract or agreement with your child care provider, regardless if your child is also authorized under a separate Child Care Assistance family;
- Renew your child care assistance participation by submitting a complete application and participating in an interview timely enough to provide for continuity of care and by the due date identified in your *Child Care Assistance Renewal Notice*;
- Review your provider's monthly request for payment to verify care was billed for the hours care was provided for your child(ren), if requested by the Department; and
- Report to local police and the Child Care Licensing Office, within 24 hours, abuse, harm, or serious risk of harm to a child in the provider's care.

### **Once I am determined eligible, what do I need to do to maintain my eligibility?**

**You must report the following to the child care assistance office within 10 business days before or after the change:**

- In your contact information to include your physical or mailing address, or contact phone number(s);
- Before changing your child care provider. You must also give your child care provider written notice at least 10 business days before the last day of child care services with that provider, specifying the last date care is to be provided except:
  - In the case of you or your child care provider's sudden program ineligibility;
  - In the case of a licensing or law-enforcement investigation of a level 1 allegation of abuse, harm, or serious risk of harm to a child in the provider's care; or
  - In the event of a death of a child;

o Upon written mutual agreement signed by the provider and yourself.

If you fail to give the required 10 business day written notice to terminate services, care may not be covered with your new provider until after the required 10 business day notice timeframe and you will have to pay out of pocket for child care services used during the 10 business day notice timeframe, which is not reimbursable by the CCAP;

- Affecting the level of child care needed, if additional care is needed. Reporting this information late may result in you owing your provider directly for the additional care provided;
- After a non-temporary (more than 3 months) loss of employment, or ending attendance at a job training or educational program. Reporting a job loss more than 10 business days after it becomes a non-temporary situation may result in a determination of an overpayment after any applicable job search time is applied, depending on when the change is reported, in which you would be required to repay the CCAP;
- After an increase in income which causes the family's monthly countable income to exceed 85% of the Alaska State Median Income for your family size. Reporting this information after the required 10 business days following the change may result in a determination of an overpayment in which you would be required to repay the CCAP;
- After a change in your family size, such as adding the second parent, which causes the family's monthly countable income to exceed 85% of the Alaska State Median Income for your new family size. Reporting this information after the required 10 business days following the change may result in a determination of an overpayment in which you would be required to repay the CCAP.

Changes not reported within 10 business days before or after the change, will not be back dated, will impact the effective date your benefit can be changed, and may result in out of pocket payments that are not reimbursable by the CCAP, and may result in a determination of an overpayment of benefits in which you would be required to repay the CCAP.

### **Your Rights**

You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor prior to requesting an administrative hearing. If the case worker or supervisor determines an error was made it will be corrected timely without the need for an administrative hearing.

### **Administrative Hearing Request**

If you disagree with a decision made by the local child care assistance office to deny your application for program participation or to reduce, suspend or terminate benefits as a participating family, you may request a hearing by submitting the *Request for Hearing* form. A written request for a hearing may be made to the Division by you or your legal representative acting on your behalf. The request must be submitted in writing within 30 calendar days of the date of the decision with which you disagree. At the hearing you may represent yourself or be represented by a legal representative. You may contact the Alaska Legal Services Corporation at [www.alsc-law.org](http://www.alsc-law.org) to see if you may qualify for free legal advice and representation.

You may continue to receive CCAP benefits until a hearing decision is made, unless your application has been denied or your case closed. If your application has been denied or your case closed and you continue to need child care assistance, it is recommended you re-apply immediately in case the hearing decision is not in your favor. If you continue to receive benefits and the hearing decision is not in your favor you will be required to repay the benefits you received while you waited for the decision.

## **Civil Rights**

Federal laws and regulations prohibit discrimination or the denial of participation on the basis of race, color, national origin, religion, sex, age, handicap or political beliefs in programs receiving federal financial assistance. To file a complaint of discrimination, write to the U.S. Department of Health and Human Services, Director, Office for Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington, D.C. 20250 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD).

## **Americans with Disabilities Act of 1990**

The Alaska Department of Health & Social Services and its grantees comply with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the Division's Americans with Disabilities Act Coordinator at (907) 465-3347.

## **Social Security Numbers**

Social Security Numbers are not required for CCAP eligibility in accordance with 45 CFR 98.71(a)(13). Eligibility may not be denied due to the failure of the applicant to provide a Social Security Number.

## **Participation Requirements**

To receive CCAP benefits, you must be participating in an eligible activity. In two-parent families both parents must be participating in an eligible activity, unless one or both parents is determined by a health care or mental health care professional to be incapacitated. Eligible activities include working, and participating in an education or training program with the intent of improving your employability.

## **Incorrect Payment of Program Benefits**

If you receive an overpayment of Public Assistance benefits or receive services to which you are not entitled, you may be financially responsible for repaying the overpayment or cost of services to the State of Alaska. This may be true even if the overpayment or improper authorization of services is due to an error on the part of the Department of Health and Social Services or its Designee. By accepting payment of benefits or services, you must understand and agree that you may be responsible for the repayment of benefits or services to which you were not entitled.

## **Fraud Penalty Warnings - Intentional Program Violation**

You may be prosecuted or otherwise penalized if you knowingly give false, incorrect or incomplete information to try to get CCAP benefits you are not eligible for, or to help someone else get benefits to which they are not eligible. If you are found to have committed an intentional program violation or are convicted of defrauding the CCAP, you may be subject to service limitations, benefit reduction, disqualification from program participation, and be obligated to repay any benefits attributable to the intentional program violation or fraudulent act(s), in addition to any applicable criminal penalties.

## **Penalties for Non-Compliance**

Your participation in the CCAP may be suspended or terminated for any of the following reasons:

- Failing to report complete, accurate, and current information regarding family income and eligibility;
- or
- Providing false or misleading information or withholding information in order to receive benefits.

If the Department determines that there is reasonable evidence of an overpayment of program benefits, the Department may take corrective action including: establishment of a repayment plan; program suspension for up to 6 months; or termination from the Program.

*Overpayment of benefits* means program benefits received by a family in which the family was not entitled to or were received while the family was in non-compliance with a program requirement.



# Child Care Assistance Application

PLEASE PRINT CLEARLY

For Office Use Only Date Received	
GREEN	RED

**Who is the family's parent?** This is the person who is requesting Child Care Assistance and assumes responsibility for compliance with program rules and requirements, including penalties and repayment of any overpaid benefits. In two parent families, both parents are responsible for compliance with program rules and requirements, including penalties and repayment of any overpaid benefits.

Full Name of Family's Parent (First, Middle, Last)		Maiden Name, if any	Social Security Number (Optional)	
Home Address		City	State	Zip Code
			AK	
Mailing Address		City	State	Zip Code
			AK	
<input type="checkbox"/> Homeless. The above addresses are for contact information only.				
Home Telephone	Work Telephone(s)	Cell Telephone	Email	
Marital Status		Other Names You Have Used		
Full Name of Family's Second Parent, if residing in the home (First, Middle, Last)		Other Names Used by Second Parent		

**Family's Primary Language, Select only One:**

- English
- Spanish
- Native Central, South American, and Mexican Languages (e.g., Mixteco, Quichean),
- Caribbean Languages (e.g., Haitian-Creole, Patois),
- Middle Eastern and South Asian Languages (e.g., Arabic, Hebrew, Hindi, Urdu, Bengali)
- East Asian languages (e.g., Chinese, Vietnamese, Tagalog)
- Native North American/Alaska Native Languages
- Pacific Island Languages (e.g., Palauan, Fijian)
- European and Slavic Languages (e.g., German, French, Italian, Croatian, Yiddish, Portuguese, Russian)
- African Languages (e.g., Swahili, Wolof)
- Other (e.g. American Sign Language): \_\_\_\_\_

**Who is Considered Part of My Family?** List each person in your family residing in the home starting with yourself. You will need to provide: 1. Proof of age for each child needing child care; and 2. Proof of citizenship for each child needing child care or the alien identification card (front and back) for each child who is not a U.S. citizen. If more space is needed, you may use a separate sheet or Page 9 of this application.

**Ethnicity:** Y= Hispanic or Latino  
N= Not Hispanic or Latino

**Race** (you may select more than one):  
AN = Alaskan Native WH = White BL = Black or African American  
AI = American Indian AS = Asian  
PI = Native Hawaiian or other Pacific Islander

Family Member Name (First, Middle, Last)	Relation- ship to you	Date of Birth MM/ DD/ YY	Social Security Number (optional)	Special Needs (as defined by 7AAC 41.990)	Gender U.S. Citizen	Ethnicity Use above codes	Race Use above codes
	<b>SELF</b>				<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
	<b>Second Parent, if residing in the home</b>				<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI

**Military. Is either parent of the family employed by a branch of the United States Military?**  Yes  No  
 If yes, Active Duty  Yes  No or Reserve/National Guard  Yes  No

**Earned Income in Your Family.**

1. Does either parent in your family receive income from a job?  Yes  No
2. If yes, what sort of income?  gross wages  salary

Explain each box you have checked in #2 above. List income for all jobs that is received or that is expected to be received for each parent in your family. Attach proof of employment, wages and earnings for the two months prior to your application submission.

Please note: Pay Frequencies of twice a month and every two weeks are different.

Family Member Name (First, Middle, Last)	Employer Name, City, Phone Number	# of Hours Worked / Week	Start Date (MM/DD/YY)	Work Schedule to include the times of day and days of the week	Hourly Wage	How Often are you Paid?
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: ____
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: ____
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: ____
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: ____

**Additional Earned Income.** This includes bonuses, commission, tips that may or may not be included on your paystubs. If yes to the following question #1, attach proof of the income.

1. Does either parent in your family receive bonuses, commission, or tips from any job?  Yes  No
2. What kind of income?  bonus;  commission;  tips;  other (explain): \_\_\_\_\_

Family Member Name (First, Middle, Last)	Employer Name, City, Phone Number	Type of additional income	Amount	Is additional income included on paystubs	How Often are these received?
		<input type="checkbox"/> Bonus <input type="checkbox"/> Commission <input type="checkbox"/> Tips <input type="checkbox"/> Other _____	\$ _____ \$ _____ \$ _____ \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> With regular pay <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Bonus <input type="checkbox"/> Commission <input type="checkbox"/> Tips <input type="checkbox"/> Other _____	\$ _____ \$ _____ \$ _____ \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> With regular pay <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Other: _____

**Self-Employment.** A person is considered self-employed if: they are not required to have federal income tax and Federal Insurance Contributions Act (FICA) tax withheld from their earnings; are not required to complete an IRS W-4 form; and are not covered by worker’s compensation. Include money received from all self-employment for all parents in your family engaged in self-employment activities. You must be receiving a net income of at least the State of Alaska minimum wage.

Is either parent in your family self-employed?  Yes  No If yes, explain in the following boxes.

If yes, attach proof of earnings and expenses or your previous year’s tax return with Schedule C and Schedule K, if applicable, and a copy of your current State of Alaska business license.

Family Member Name (First, Middle, Last)	Name of and Type of Business	Seasonal (S) or Year-round (Y) Activity?	If (S) seasonal, provide dates of the most recent season and current/next season	Work Schedule	Business Income- For the three months prior to the month of application submission	Business Expenses- For the three months prior to the month of application submission
		<input type="checkbox"/> S <input type="checkbox"/> Y	Most recent season: _____ Current/next season: _____			
		<input type="checkbox"/> S <input type="checkbox"/> Y	Most recent season: _____ Current/next season: _____			

**Education or Training Program.** Does either parent in your family attend a job training or educational program?  Yes  No

If yes, attach proof of course enrollment, schedule, cost of tuition and fees (this could be on an account summary by term), financial aid received or will be received by each parent engaged in an educational activity, and copies of receipts for any books or supplies purchased.

Name of Person in Activity	Type of Activity <input type="checkbox"/> Education <input type="checkbox"/> Training	Name of Training/ Educational Institution	Start Date (MM/DD/YY)	End Date (MM/DD/YY)
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List the days and times you expect to participate in each activity. If your schedule varies, please explain:

Total anticipated hours of all activities:

Name of Person in Activity	Type of Activity <input type="checkbox"/> Education <input type="checkbox"/> Training	Name of Training/ Educational Institution	Start Date (MM/DD/YY)	End Date (MM/DD/YY)
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List the days and times you expect to participate in each activity. If your schedule varies, please explain:

Total anticipated hours of all activities:

**Deductible Child Support Expenses.** Only legally obligated child support payments may qualify. Does either parent in your family pay child support to someone outside of the home?  Yes  No If yes, name of person paying child support: \_\_\_\_\_ Monthly amount: \$ \_\_\_\_\_

If yes, attach proof of payments made in the 3 months prior to application submissions. For example, pay stubs reflecting the child support garnishments.

**Housing Assistance.** Do you receive a housing voucher or cash assistance for housing?  Yes  No (Mark "No" if living on a military installation)

**Family Assets.** Assets include but are not limited to: items of ownership convertible into cash; notes and accounts receivable, securities, or real estate. Does your family have combined assets totaling more than \$1,000,000.00?  Yes  No

**Unearned Income.** Do you or anyone in your family receive money from any other source (unearned income)?  Yes  No

On the following page, list any other money you or anyone in your family (parents and children) receives other than earned income or self employment and **attach proof** of the amount and frequency for each type of unearned income received. The Alaska Permanent Fund Dividend is not counted for any member of your family.

Acronym identification:

ATAP = Alaska Temporary Assistance Program

SSA/SSI = Social Security Administration / Supplemental Income

UIB= Unemployment Insurance Benefit

VA= Veteran's Administration

Name of Person Receiving Unearned Income (First, Middle, Last)	Source of Unearned Income Amount Received / Frequency Received (weekly, every 2 weeks, twice a month, monthly, quarterly, annually, other - explain)			
	<input type="checkbox"/> Child Support \$_____/how often_____	<input type="checkbox"/> ATAP \$_____/how often_____	<input type="checkbox"/> SSA/SSI \$_____/how often_____	<input type="checkbox"/> UIB \$_____/how often_____
	<input type="checkbox"/> Native Corp. Distribution \$_____/how often_____	<input type="checkbox"/> Adoption Payments \$_____/how often_____	<input type="checkbox"/> VA \$_____/how often_____	<input type="checkbox"/> Other:_____ \$_____/how often_____
	<input type="checkbox"/> Education Financial Aid \$_____/how often_____	<input type="checkbox"/> Foster care Payment \$_____/how often_____	<input type="checkbox"/> Guardian \$_____/how often_____	
	<input type="checkbox"/> Child Support \$_____/how often_____	<input type="checkbox"/> ATAP \$_____/how often_____	<input type="checkbox"/> SSA/SSI \$_____/how often_____	<input type="checkbox"/> UIB \$_____/how often_____
	<input type="checkbox"/> Native Corp. Distribution \$_____/how often_____	<input type="checkbox"/> Adoption Payments \$_____/how often_____	<input type="checkbox"/> VA \$_____/how often_____	<input type="checkbox"/> Other:_____ \$_____/how often_____
	<input type="checkbox"/> Education Financial Aid \$_____/how often_____	<input type="checkbox"/> Foster care Payment \$_____/how often_____	<input type="checkbox"/> Guardian \$_____/how often_____	
	<input type="checkbox"/> Child Support \$_____/how often_____	<input type="checkbox"/> ATAP \$_____/how often_____	<input type="checkbox"/> SSA/SSI \$_____/how often_____	<input type="checkbox"/> UIB \$_____/how often_____
	<input type="checkbox"/> Native Corp. Distribution \$_____/how often_____	<input type="checkbox"/> Adoption Payments \$_____/how often_____	<input type="checkbox"/> VA \$_____/how often_____	<input type="checkbox"/> Other:_____ \$_____/how often_____
	<input type="checkbox"/> Education Financial Aid \$_____/how often_____	<input type="checkbox"/> Foster care Payment \$_____/how often_____	<input type="checkbox"/> Guardian \$_____/how often_____	

**Deductible catastrophic medical or dental payments.** Does your family have medical or dental payments, including premium payments, which exceed 10% of the family's gross monthly income; payments have been made for more than 60 days; and are projected to be an ongoing expense for more than six months?

Yes  No

If yes, attach proof of payments made in the last 60 days.

**Child Custody Arrangement.** Your arrangement can be either court ordered or informally agreed upon. Is there a custody arrangement for any of the children listed on the application who will need child care?  Yes  No  
 Attach the child custody arrangement portion of your court order, if applicable. An affidavit or written statement from the other parent must be submitted if informally agreed upon.

Child's Name (First, Middle, Last)	Days and times child is with you. Please indicate drop off/pick up times.	Court Ordered
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Child's School Schedule.** Do any of the children listed on the application who need child care attend elementary school?  Yes  No If yes, tell us your child's school information, to determine the unit of care needed.

Child's Name (First, Middle, Last)	Name of Elementary School, Pre-Elementary School, Early Head Start, or Head Start program each child attends and the child's grade		Days and Times school is in session	Full day care needed for In-service /School closures	How does each child get to and from school	Time a.m. child leaves provider/ time p.m. child returns to provider	
	School Name	Grade				Leaves a.m.	Returns p.m.
	School Name	Grade		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leaves a.m.	Returns p.m.
	School Name	Grade		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leaves a.m.	Returns p.m.
	School Name	Grade		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leaves a.m.	Returns p.m.
	School Name	Grade		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leaves a.m.	Returns p.m.
	School Name	Grade		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leaves a.m.	Returns p.m.
	School Name	Grade		<input type="checkbox"/> Yes <input type="checkbox"/> No		Leaves a.m.	Returns p.m.

**Child Care Needs.** Based on parent activities, custody/visitation and children’s school schedules listed on the previous pages, tell us when each child will need care. The provider you select must be either Licensed or Approved to participate in the Child Care Assistance Program, by the State of Alaska or local designee, before any benefit will be paid on your behalf. If any child listed on the application does not need child care, do not include them below.

Child’s Name (First, Middle, Last)	Days and Times Child Care Needed	Primary Child Care Provider Name / Address	Secondary Child Care Provider Name / Address

**Preferred Interview Day / Timeframe and Method:**  Telephonic  In-Person at CCA Office. The parent listed at the top of Page 1 of this application is required to participate in an interview. Your preferred day/time will be honored whenever possible; however, due to multiple requests for the same day/time it may not be possible. Please provide more than one preferred day/time so your interview can be completed in a timely manner.

<b>Day(s) of the week preferred:</b>	<b>Best time of the day:</b>
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**In-Home Provider Information.**

Under limited circumstances, outlined in 7 AAC 41.370, you may select an individual to provide child care services in your home. You are considered the employer and are required to complete an additional *In-home Child Care application*. You are responsible for compliance with all labor and IRS laws and requirements. There may be a lapse in eligible coverage as approval and effective start dates for In-home caregivers is the first of the month following receipt of all the required information. This may require you to pay your caregiver out-of-pocket for child care. These costs will not be covered by the Child Care Assistance Program. Your In-home caregiver may not reside in your home and may not care for another family’s children. Your caregiver may not bring their own children, if any, to your home while caring for your children, unless there will be a maximum of no more than five children younger than thirteen and only with your written permission.

Child care will be provided in my own home (In-home Care) by (caregiver’s name): \_\_\_\_\_



**Statement of Truth, Rights and Responsibilities and  
Authorization for Release of Information**

**Statement of Truth and Rights and Responsibilities**

Under penalty of perjury or unsworn falsification, I certify that the statements made on this application and during my interview for assistance regarding the persons in my family, my family's income, participation in eligible activities, and all other items that pertain to my family's possible eligibility for Child Care Assistance Program benefits are true and correct to the best of my knowledge. I have read and kept a copy of the "Your Rights and Responsibilities" portion of this application and by signing below, agree to comply with the requirements for participation in the program and certify the statements are true.

**Authorization For Release Of Information**

I authorize the release of information requested by the Department of Health and Social Services, its designees, or its agents within the Department of Law. The requested information will only be used in the administration of the Child Care Assistance Program or other public assistance programs, and unless allowed by law, will not be released to any other person or agency outside the Department of Health and Social Services, its designees, or its agents within the Department of Law.

This release of information will be in effect while I am an applicant or recipient of the Child Care Assistance Program or other public assistance programs, and for any later investigations pertaining to my eligibility and program benefits.

Persons or organizations that may be contacted include, but are not limited to: employers, landlords, school authorities, Alaska Departments of Law, Labor, Revenue, Public Safety, Fish & Game, Military and Veterans Affairs; Bureau of Citizenship and Services; Alaska Housing Finance Corporation; Social Security Administration; tax assessors; financial institutions; stock brokerage firms; local governments; public assistance program contractors and grantees; native corporations and private individuals.

I have read the definition of family and have included on this application everyone who is part of my family and reported all income and activities for every person in my family.

\_\_\_\_\_  
Printed Name of Family's Parent

\_\_\_\_\_  
Signature of Family's Parent

\_\_\_\_\_  
Address

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Second Parent Applicant

\_\_\_\_\_  
Signature of Second Parent Applicant

\_\_\_\_\_  
Address

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

\_\_\_\_\_  
Date

**A Copy of this Release is as Valid as the Original.**