



CHILD CARE PROGRAM OFFICE
 3601 C St, Ste # 140 ~ PO Box 241809
 Anchorage, AK 99524-1809
 Phone: (907) 269-4500 Toll Free: (888) 268-4632

For Office Use Only

CHILD CARE GRANT (CCG) REIMBURSEMENT REQUEST (Manual)

ICCIS #:^a PVN #:^b

Facility Name:^c

Physical Location of Facility:^d

City:^e Zip:^f

Mailing Address:^g

City:^h Zip:ⁱ

Has any information above changed?:^j YES **If YES, contact licensing^k**

Report Month/Year:^l /

- Write the number of full-time equivalent children in care for the report month:
- Divide **Line 1** by 21.7 (Average Daily Attendance):
- Enter the geographically adjusted rate for your community from the Child Care Grant Rate Schedule:
- Multiply **Line 2** by **Line 3**. This is your maximum qualifying reimbursement amount: \$
- CCPO USE ONLY: CCG reimbursement amount approved for payment and supported by attached receipts. \$

- Number of children with CCAP authorizations (C)
- Number of children with OCS authorizations (O)
- Number of all other children (S)
- Total children in care (total of Lines 6 through 8)
- ATTENDANCE MINIMUM:

11. Specify how Child Care Grant Funds were spent during the report month (*check all that apply and enter amount*):

Expenditure Category	Amount (\$)
<input type="checkbox"/> Staff salaries & benefits	\$ <input type="text"/>
<input type="checkbox"/> Substitute care, cost associated with providing	\$ <input type="text"/>
<input type="checkbox"/> Supplies, equipment & activities costs for children	\$ <input type="text"/>
<input type="checkbox"/> Health & safety costs	\$ <input type="text"/>
<input type="checkbox"/> Child development education & training for staff	\$ <input type="text"/>
<input type="checkbox"/> OTHER: Requires CCPO Pre-approval	\$ <input type="text"/>

Total is supported by attached receipts or attached documentation and may not exceed the maximum qualifying reimbursement amount in **Line 4**. Total \$

¹² STATEMENT OF TRUTH: Under penalty of perjury or unsworn falsification, I certify that the information provided on this form and all accompanying daily CCG Attendance forms for the period indicated are true and accurate. I understand that if I provide false information on or with this form, any money obtained as a result must be paid back to the State of Alaska and I may not be able to participate in the Child Care Grant Program in the future. **I understand that this payment request must be received by the last day of the month following the report month or payment will be denied.**

Printed Name of Individual With Signatory Authority _____ Signature of Individual With Signatory Authority _____ Contact Telephone Number _____ / / _____ Date

CCPO ACCOUNTING USE ONLY: Approved for Payment Signature: _____ Date: ____/____/____ **CODING:**