Office Use Only

CHILD CARE GRANT PROGRAM

Division of Public Assistance
Child Care Program Office
3601 C Street, Suite 140
PO Box 241809, Anchorage, AK 99524-1809

REIMBURSEMENT REQUEST FOR STAFF SALARIES AND BENEFITS OR SUBSTITUTE CARE

Service Month:_____ ICCIS Number:_____

Facility Name:_____ Phone:_____

Mailing Address:_____

City:_____ Zip:_____

☐ Per 7 AAC 39.040(a) (1) the funds requested through the Child Care Grant Program for reimbursement were used for staff salaries and benefits for the individual staff member(s) listed below:

_____

_____

OR

☐ Per 7 AAC 39.040(a) (2) the funds requested through the Child Care Grant Program for reimbursement were used for providing substitute care for the days or timeframe of _____ for the individual(s) listed below:

_____

_____

By signing below I certify under penalty of perjury all the information contained on this form is true and correct. I understand that if I provide false information on this or any other form submitted in relation to Child Care Grant Program payments, any money obtained as a result must be repaid and I may be subject to sanctions under 7 AAC 39.060.

_____
Printed Name of individual with CCG signing authority

_____ _____
Signature of individual with CCG signing authority Date