



# CHILD CARE GRANT PROGRAM

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

Office Use Only
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## CHILD CARE GRANT REIMBURSEMENT REQUEST FOR STAFF SALARIES AND BENEFITS OR SUBSTITUTE CARE

Service Month: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ ICCIS Number: \_\_\_\_\_

Per 7 AAC 39.040(a) (1) the Child Care Grant Reimbursement Request was used for staff salaries and benefits for the individual staff member(s) listed below:

\_\_\_\_\_  
\_\_\_\_\_

OR

Per 7 AAC 39.040(a) (e) the Child Care Grant Reimbursement Request was 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 payments, any money obtained as a result must be repaid and I may be subject to sanctions under 7 AAC 39.060.

\_\_\_\_\_  
Printed Name individual with CCG signing authority

\_\_\_\_\_  
Signature of individual with CCG signing authority

\_\_\_\_\_  
Date