



CHILD CARE ASSISTANCE PROGRAM

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

Office Use Only

FAMILY REPORT OF CHANGE

Printed Family First and Last Name: ICCIS Case Number, if known:

EMPLOYMENT CHANGE

Employment Ending Parent name: Employer Name: Last Day Worked: Date final pay issued:

Employment Beginning Parent name: Employment Start Date: Employer Business Name: Contact Name and Number: Schedule of work days and times: Hourly rate of pay: How often/when paid:

Change in schedule /days/times / rate of pay Parent name: Employer Name: Contact Name and Number: Schedule of work days and times: Hourly rate of pay: How often/when paid:

CHANGE IN UNEARNED INCOME

Increase of \$200 or more per month Decrease not due to employment change above Family Member Name: Name/type of income source changing: Date received: Amount received: New amount to continue: Yes No

CHANGE IN FAMILY COMPOSITION / CUSTODY

Marital Status Change Parent Name: Spouse Name: Marriage Date: Legally Separated effective Date: Divorced effective Date: Name Change Parent Name: New Name: Copies of legal documentation applicable to the change indicated must be provided. Other parent of child(ren) enters or leaves the home Date entered/left: Other parent name: Custody Change Effective Date: Copies of legal documentation applicable to the custody change must be provided. Child(ren) name:

CHANGE IN CHILD CARE NEED

Change in days / hours Child(ren) Name _____
Child Care Provider Name: _____
Days / Times care needed: Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

CHANGE OF CHILD CARE PROVIDER

Current Child Care Provider Name _____
Date 14 day written notice given to this provider: _____ Last date of care: _____
Child(ren) Name: _____

New Child Care Provider Name _____
Date care to begin: _____
Child(ren) Name: _____

Secondary Provider Needed
Child Care Provider name: _____
Date Care to begin: _____ Child(ren) Name: _____
Days / Times care needed: Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

CHANGE IN FAMILY ADDRESS / CONTACT INFORMATION

MAILING ADDRESS CHANGE
New mailing address: _____
Effective date of change: _____ Same as physical address: **Yes** **No**

PHYSICAL ADDRESS CHANGE
New physical address: _____
Effective date of change: _____ Same as mailing address: **Yes** **No**

CONTACT PHONE NUMBER CHANGE
Home phone number: _____ Work phone number: _____
Cell phone number: _____ Other contact number: _____

Comments:

Family's Responsible Party Signature: _____

Date: _____