Office Use Only

CHILD CARE ASSISTANCE PROGRAM
ALASKA INCLUSIVE CHILD CARE PROGRAM

Division of Public Assistance
Child Care Program Office

FINANCIAL REPAYMENT AGREEMENT

I _____ acknowledge that I have been overpaid the sum of $_____
(Provider Name)
from the Division of Public Assistance, Child Care Assistance Program (CCAP). Which occurred during the period of _____ through _____.
MM/DD/YYYY MM/DD/YYYY

I acknowledge that I am obligated to repay the aforementioned amount to the State of Alaska.

I understand if at any time I am receiving payment from the CCAP, the Child Care Program Office or Child Care Assistance Office will deduct $_____ from my payment(s) until the sum is paid in full.

If I am not receiving payments from the CCAP, the Child Care Program Office will deduct the above amount from any payment to me through the Child Care Grant Program. If I am not receiving payments from either of these programs during any month, I agree to repay the State of Alaska the total sum of $_____, as follows:

A. I will pay the entire amount in full within 30 days to be submitted by _____
MM/DD/YYYY

B. I will make an initial payment amount of $_____ on or before _____
MM/DD/YYYY

The remainder will be paid in installments of $_____, payable on or before the 15th day of each month thereafter beginning _____.
MM/DD/YYYY

I agree to make payments in the form of a cashier check or money order payable to the State of Alaska and will mail the payment to the Child Care Program Office at PO Box 241809, Anchorage, AK 99524 or deliver it to 3601 C Street, Ste 140 Anchorage.

I understand garnishment action will be taken against my Alaska Permanent Fund Dividend payment for up to the remaining balance each year until my debt is paid in full.

I understand that if I fail to make a payment on or before the date specified in B. above, the unpaid balance will become payable in full and the State of Alaska, upon providing thirty (30) days written notice to me, may take legal action against me. Failure by the State of Alaska to immediately take action to collect this debt shall not constitute a waiver of any of the State's rights, including the right to accelerate this agreement in the event of any subsequent default in the payment of this debt.

I understand my failure to comply with an established Financial Repayment Agreement may result in further collection actions and my name being removed from the list of eligible providers. I further understand I will not be able to participate in the CCAP until I come into compliance with the established Financial Repayment

Agreement by paying the balance of all delinquent months and my name is placed back on the list of eligible providers; payment may be made in full at any time; and program participation is contingent upon timely receipt of payments.

If legal action is commenced to collect this debt or any part thereof, I promise to pay, in addition, reasonable costs and attorney's fees incurred in bringing forward this action.

I understand and agree I may not assign this debt without the written consent of the State of Alaska.

_____ _____

Printed Name of Provider Date

_____

Signature of Provider

_____ _____

Mailing Address of Provider Telephone Number of Provider

SUBSCRIBED AND SWORN TO before me this _____ day of_____, 20_____.

_____

Notary Public _____

My Commission Expires_____