



CHILD CARE ASSISTANCE PROGRAM
ALASKA INCLUSIVE CHILD CARE PROGRAM

Office Use Only

Division of Public Assistance
Child Care Program Office

FINANCIAL REPAYMENT PLAN ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have been overpaid the sum of \$ from the Division of Public Assistance, Child Care Assistance Program (CCAP). Which occurred during the period of through.

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 monthly payment(s) beginning (Month Day, Year) through (Month Day, Year) or 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 make direct payments to repay the State of Alaska the total sum of \$. Repayment will be completed within 3 years, 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, or through Bill Pay with my financial institution. Payments in the form of cashier check or money order will be mailed to the Benefits Issuance and Recovery Unit at PO Box 110640, Juneau, AK 99811-0640

I understand garnishment action will be taken against my personal future Alaska Permanent Fund Dividend payments for up to the remaining balance each year, if I am delinquent in my payments, 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 Plan and 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 Plan and 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 _____