ALASKA INCLUSIVE CHILD CARE PROGRAM

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

Office Use Only

APPLICATION FOR ALASKA INCLUSIVE CHILD CARE

A child with special needs as described in 7 AAC 57.940 who is under 13 year of age may qualify for a supplemental program rate if the child's special needs are documented by a health professional; and the provider establishes, in consultation with the child care resource and referral agency assisting the family, that the child requires additional services due to the child's special needs, and that those services have an additional cost. Additional funding may be approved as a one-time payment or multiple payments depending on the child's specific needs and the additional cost for services and/or accommodations provided.

Printed Full Name of Family's Responsible Party (First, Middle, Last)			
Home Address	City	State **AK**	Zip Code
Mailing Address	City	State **AK**	Zip Code

Home Telephone	Work Telephone(s)	Cell Telephone	E-mail

Child's Name (First, Middle, Last)	Date of Birth:
Child's Name (First, Middle, Last)	Date of Birth:
Child's Name (First, Middle, Last)	Date of Birth:
Child's Name (First, Middle, Last)	Date of Birth:

Child Care Provider Name			**Contact Phone:**
Physical Address	**City**	**State** AK	**Zip Code**
Mailing Address	**City**	**State** AK	**Zip Code**

I understand I must be eligible to receive State of Alaska Child Care Assistance and Alaska Inclusive Child Care Programs in order for my child(ren)'s child care provider to receive supplemental funding.

______________________________ ____________________
Signature of Family's Responsible Party Date

RELEASE OF INFORMATION

My signature below authorizes the release of information requested by the Department of Health and Social Services, its designee, the Alaska statewide Child Care Resource and Referral (CCR&R) Network, thread, or its agents within the Department of Law. The requested information will only be used in the administration of the Alaska Inclusive Child Care Program, and unless allowed by law will not be released to any other person or agency outside the Department of Health and Social Services, its designees, or its agents within the Department of Law. Any information relevant to a determination of whether a member of my family qualifies for the Alaska Inclusive Child Care Program may be released including records related to medical, psychiatric, services provided, assessments, child care, or other services provided to a family member.

This release of information will be in effect while I am an applicant or recipient of the Alaska Inclusive Child Care Program and for any investigation pertaining to my eligibility and/or program benefits.Persons or organizations that may be contacted include, but are not limited to: physicians; health care professionals; mental health care professionals; child care providers; Alaska statewide Child Care Resource and Referral Network; individual service providers; schools; or other agencies identified as providing services to the child.

I hereby authorize the use or disclosure of my family's health care and/or other information as described on this release. I understand that that these records may contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individuals or organizations releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the persons or organizations authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization is valid for 12 months from the date it is signed. Each individual or agency listed will receive only the information pertaining to them to ensure confidentiality.

____________________________________ ___________________________

Signature of Family's Responsible Party Date

☐ Child Care Provider Name: ____

Physical Address: ____

Mailing Address: ____

Contact Phone: ____

☐ Health Care Professional Name: ____

Physical Address: ____

Mailing Address: ____

Contact Phone: ____

☐ School or Agency Providing Services

Name of School or other Agency:____

Name of Individual Contact Person: ____

Physical Address: ____

Mailing Address: ____

Contact Phone: ____