



CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance

Child Care Program Office

Office Use Only

SUPPLEMENTAL PAYMENT REQUEST

Submit this form to the child care assistance office serving your region only when payment for the child has already been made to the child care provider for the service month and a supplemental payment is requested. Supplemental requests for child care providers in the Municipality of Anchorage are to be submitted to the Child Care Program Office.

Family Name: _____

Family ID #: _____

Supplemental Payment requested for Month and Year (MM/YYYY):

Child Care Provider/Facility Name:

Child Care Provider/Facility ICCIS ID#:

First and Last Name of Child(ren):

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Additional Units of Care Requested:

Reason for Additional Care Requested:

Requestor's Printed Name:

Requestor's Direct Phone Number:

Requestor's Agency Name:

Date: