State of Alaska
Department of Health and Social Services - Division of Public Assistance
Child Care Program Office

REQUEST FOR PASS I CHILD CARE

Office Use Only

Care Begins	
Care Ends	

Fax: 907-269-4536 or 1-888-268-4632
Email: CR_Childcare@alaska.gov

Date Submitted: _____

Authorization Type (initial/revised/cancel): _____

Case Manager Name: _____

Agency Name: _____

Case Manager Phone: _____

Parent(s) Information and Work Activity ***(include all eligible activities for each parent)***

Client ID	Parent(s) Name *(as shown in CMS)*	Phone	CMS Activity Code	# Hours/Week	# Days/Week	Organization Name

Name of Child(ren) *(as shown in CMS)*	**Facility Name** ***must include full, exact name of facility.** Refer to Facilities Database for information	**Facility Address** ***or*** **New Provider Mailing Address*** ***MUST be provided if facility is new/not listed in database**	**Facility Phone** *per Facilities Database or New Provider contact number	**(P)rimary or (S)econdary**	**Is Provider Related to Child in Care? (Y/N)**	**Part time (PT), Full Time (FT), Hourly (H)**	**No. of Days in Care *or* Mark with "X" if want PT/FT full month**	**(E)nrollment or (A)ttendance**	**Additional Care** *care requested to exceed 10 hrs/day (must justify in Comments)	
									Hrs/Day	**Days/Mo.**

Alaska IN! Supplement Information		**Supplement % Amount**	**Proof Attached?**
Child's Name:			
Child's Name:			

Part Time = 2 or more hours up to and including 5 hours of care per day
Full Time = 5 hours up to and including 10 hous of care per day
Hourly = 1 or 2 hours of care per day

Comments: Use this space to justify request for payment to exceed state maximum, change in provider/termination of care agreement on file or other information that could affect the authorization issued by DPA:

CC 1 (06-3889) rev 4/11
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