Application for Child Care Assistance

State of Alaska
Department of Health
Child Care Program Office

Where do I send my application? You will apply at your local Child Care Assistance office based on the community where you reside. The offices listed below can also assist you with completing the application process or answer any questions you have regarding child care assistance. To reduce processing time and avoid delays, use the checklist on pages 5 and 6 for additional verification that is required with your application. **Keep a copy of the entire application and checklist for your records.**

The office serving families and provider in the **Municipality of Anchorage** areas include Anchorage, Bird Creek, Chugiak, Eagle River, Girdwood, and JBER

Alaska Family Services Inc.
2525 Gambell St. Suite 220
Anchorage, AK 99503
Phone: (907) 644-5000
Fax: (907) 644-5020
Email: ccaanc@akafs.org

The office serving families and providers in **Central and Coastal** areas**:**
Central areas include Cordova, Palmer, Valdez, Wasilla and Willow
Coastal areas include the Aleutian Chain, Bristol Bay Area, Kenai Peninsula, Kodiak, Kotzebue and Nome

Alaska Family Services Inc.
777 N. Crusey St., Ste B201
Wasilla, AK 99654
Phone: (907) 373-4450
Toll-free: 1-866-746-4080
Fax: (907) 373-4468 or Toll-free fax: 1-888-415-6868
Email: centralcca@akafs.org for Central
Email: coastal.cca@akafs.org for Coastal

The office serving families and providers in **Northern and Southeast** areas:
Northern areas include Barrow, Eielson AFB, Fairbanks, Gustavus, Moose Creek, North Pole, North Slope, and Salcha
Southeast areas include Juneau, Petersburg, Haines, Hoonah, Ketchikan, Metlakatla, Angoon, Craig, Prince of Wales, Sitka, Skagway, Tok, Wrangell, and Yakutat

thread
1949 Gillam Way, Ste G Fairbanks, AK 99701
Phone: (907) 479-2212
Toll-free: 1-855-479-2212
Fax: (907) 479-2295 or Toll-free fax: 1-855-479-2295
Email: CCAthread@threadalaska.org

Questions and Answers

Who is considered part of my family for Child Care Assistance? Your family includes: *yourself, the other parent of the children who lives in the home regardless if you are married or not and each of your children who are under 18 years of age.*

A parent is also considered part of the family who is:

- Away from the family home due to participating in an eligible activity and the home is still their residence; or
- Married parents who are living apart are considered part of your family if the parent retains the home as their residence, or intends to return to the family home; or
- A legal guardian who has financial responsibility for the children even if the children are not biologically yours.

Is an interview required? Yes. An interview is required with the parent(s) of the family before it can be determined if you are eligible for assistance. Your interview may be in person or by telephone. Your application will be denied if you do not complete an interview or provide information that is needed for your application.

How much can I make and still qualify? Financial eligibility is based on the total monthly gross income and by family size. This also determines the family's contribution (co-pay). The most current income limits and the co-pay amount you would owe can be found on the *Family Income and Contribution Schedule* located on the Child Care Program Office website at: https://health.alaska.gov/dpa/Pages/ccare/forms.aspx

Will I have to pay anything? Yes, you will owe your provider money.

- A family contribution (co-pay) is a fee that you will pay your provider which is based on your gross income; and
- If your provider charges more than the state rate you will owe the difference. It is recommended that you speak to your provider about the difference in their rates and the state rate so you can plan for that monthly payment.

The state will pay your provider directly the lesser of the provider rate or the state rate. To find the most current *Child Care Assistance Program Rate Schedule,* go to the Child Care Program Office website at**:** https://health.alaska.gov/dpa/Pages/ccare/forms.aspx

When will my benefits begin if I am determined eligible? If eligible, you will receive a notice of approval that will show your certification period start date and is usually the date the application was received by the Child Care Assistance Office, as long as all the required documentation is received within 30 days.

Which child care provider(s) can I use? Child care providers must participate in the Child Care Assistance Program (CCAP). A provider cannot be paid by the CCAP on behalf of CCAP participating families, until the provider has applied and received approval to participate.. The Child Care Resource and Referral agency can provide a list of participating providers in your area. Visit www.threadalaska.org for more information.

Your Rights and Responsibilities

The Child Care Assistance Program State Regulations 7 AAC 41. as well as the Child Care Assistance Program Policies and Procedures are available on the Child Care Program Office website at: https://health.alaska.gov/dpa/Pages/ccare/regs.aspx

Your Responsibilities

You must provide complete, accurate, and current information regarding children, family income, hours of employment or training, and other factors that affect eligibility for program benefits. A family must provide documentation to support information provided on the application.

You are required to:

- Select a provider who is also approved to participate in the Child Care Assistance Program;
- Participate in an eligible activity which includes work or participating in an education or training program; In two-parent families, both parents must be in an eligible activity, but consideration is allowed if one parent is determined by a health care or mental health care professional to be incapacitated;
- Pay your child care provider each month, your monthly contribution (co-pay) AND the difference between what your provider charges and what the CCAP pays on your behalf;
- Renew your child care assistance participation every 12 months by the due date identified in your *Child Care Assistance Renewal Notice*;
- Review your provider's monthly Request for Payment to verify care was billed for the hours care was provided for your child(ren), if requested by the Department; and
- Report to local police and the Child Care Licensing Office, within 24 hours, abuse, harm, or serious risk of harm to a child in the provider's care.

Changes you are required to report within 10 business days:

Changes **not** reported within 10 business days, will not be back dated and may result in out-of-pocket payments to your provider that are not reimbursable by the CCAP. The untimely report may result in an overpayment of benefits in which you may be required to repay the CCAP. Changes required to be reported include:

- A change in your physical or mailing address, or contact phone number(s);
- Before a change in your child care provider, you must provide 10 business days written notice to the provider. The notice must have the last date care is to be provided and a copy submitted to your local CCAP office as part of your report of change in child care providers;
- If you need additional care due to a change in the eligible activity;
- A loss of an eligible activity where the parent will not return to that activity within the 12-month certification period;
- After an increase in income which causes the family's monthly countable income to exceed the income limit for your family size; and
- Changes causing your monthly income to exceed 85% of the state median income (program income limit). Example: After a change in your family size, by adding a second parent, which causes the family's monthly countable income to increase and exceed the income limit for your new family size.

Your Rights:

You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor prior to requesting an administrative hearing. If the case worker or supervisor determines an error was made it will be corrected timely without the need for an administrative hearing.

Administrative Hearing Request

If you disagree with a decision made by the local child care assistance office and receive a notice that denies your application or reduces, suspends or terminates benefits as a participating family, you may request a hearing by submitting the *Request for Hearing* form. A written request for a hearing may be made to the Division by you or your legal representative acting on your behalf. The request must be submitted in writing within 30 calendar days of the date of the decision with which you disagree. At the hearing you may represent yourself or be represented by a legal representative. You may contact the Alaska Legal Services Corporation at www.alsc-law.org to see if you may qualify for free legal advice and representation.

If your application has been denied or your case has closed, you are not able to continue to receive CCAP benefits. If your application has been denied or your case closed, it is recommended you re-apply immediately in case the hearing decision is not in your favor. If you continue to receive benefits and the hearing decision is not in your favor, you will be required to repay the benefits you received while you waited for the decision.

Civil Rights

Federal laws and regulations prohibit discrimination or the denial of participation on the basis of race, color, national origin, religion, sex, age, handicap, or political beliefs in programs receiving federal financial assistance. To file a complaint of discrimination, write to the U.S. Department of Health and Human Services, Director, Office for Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington, D.C. 20250 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD).

Americans with Disabilities Act of 1990

The Alaska Department of Health & Social Services and its grantees comply with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the Division's Americans with Disabilities Act Coordinator at (907) 465-3347.

Social Security Numbers

Social Security Numbers are not required for CCAP eligibility in accordance with 45 CFR 98.71(a)(13). Eligibility may not be denied due to the failure of the applicant to provide a Social Security Number.

Incorrect Payment of Program Benefits

If you receive an overpayment of Public Assistance benefits or receive services to which you are not entitled, you may be financially responsible for repaying the overpayment or cost of services to the State of Alaska. This may be true even if the overpayment or improper authorization of services is due to an error on the part of the Department of Health or its Designee. By accepting payment of benefits or services, you must understand and agree that you may be responsible for the repayment of benefits or services to which you were not entitled.

Fraud Penalty Warnings - Intentional Program Violation

You may be prosecuted or otherwise penalized if you knowingly give false or misleading information, incorrect or incomplete information to try to get CCAP benefits you are not eligible for, or to help someone else get benefits for which they are not eligible. If you are found to have committed an intentional program violation or are convicted of defrauding the CCAP, you may be subject to service limitations, benefit reduction, disqualification from program participation, and be obligated to repay any benefits attributable to the intentional program violation or fraudulent act(s), in addition to any applicable criminal penalties.

Checklist for Verification Needed with the Application

Use this checklist to help gather documents that are needed with your application. If additional information is needed or missing, you will be sent a notice. Be sure to open and read your mail as the agency is required to communicate by written communication and notices are time sensitive.

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An unexpired government issued photo identification: An ID is needed for each parent listed on the application.

☐ Unexpired government issued ID for Parent 1

☐ Unexpired government issued ID for Parent 2

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Verification of age for each child needing child care assistance: The verification must show the child's legal name and date of birth. Acceptable verification may include one of the following:

☐ Birth certificate or adoption record

☐ Hospital crib card, hospital or midwife birth record

☐ Government issued photo identification

☐ Supplemental Security Income (SSI) records

☐ Immigration or naturalization records

☐ Passport

☐ School record

☐ Denali Kid Care card

☐ Certificate of Indian blood

☐ Court records.

Verification of citizenship for each child needing child care assistance. If not a U.S. citizen, proof verification of alien status must be provided. Acceptable verification may include one of the following:

☐ Birth Certificate

☐ Certificate of citizenship or naturalization provided by the USCIS

☐ US passports

☐ Other official government issued identification verifying citizenship or immigration status

☐ Hospital record of birth that includes the child's name, date of birth, hospital name and location of the hospital city and state

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Gross earned income for ALL jobs for each parent and/or spouse: Verification of all gross income received for each parent on the application. Include the following applicable verification:

☐ Pay stubs for the two full months prior to the month of your application submission

☐ For new employment, an employment verification letter from your employer or Employment Statement

☐ Bonus or Commission Income

☐ Tips, if not on the paystubs provide a Monthly Tip Ledger
https://health.alaska.gov/dpa/Pages/ccare/forms.aspx

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Unearned income for ALL members of your family: **Verification** of unearned income for all members of the family. Unearned income includes, but is not limited to:

☐ Public Assistance Cash Program:

☐ Unemployment Insurance Benefit:

☐ Native Corp. Distribution:

☐ Foster Care Payments:

☐ Employer paid housing:

☐ Investments Income/Capital Gains:

☐ Interest/Estate Payments/Royalties:

☐ Social Security/Supplemental Income:

☐ Veteran's Administration:

☐ Adoption Payments:

☐ Guardian Payments:

☐ Rental Income:

☐ Retirement/Pension Income:

☐ Other: _____

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Self-employment for each parent engaged in self- employment activity:

☐ A copy of your current State of Alaska business license (this is a program requirement); and

☐ A copy of your most recently completed Federal tax return with schedule C and schedule K; or

☐ Self-Employment Income/Deduction Worksheets for 3 full months prior to your application along with copies of receipts for your expenses (deductions) for the 3 months reported.
https://health.alaska.gov/dpa/Pages/ccare/forms.aspx

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Education/Training Program: Provide verification of education/training for each parent attending an education or training program. Verification is needed for the program attended;

☐ A copy of your current and/or future school schedule start and end time for classes, If you are participating in practicum or an internship, verification of this schedule will be required"; and

☐ Verification of current and/or future financial aid/account summary by term, for money received for college; and

☐ Verification of tuition, fees, and books

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Possible Deductions to Income: Provide verification of ongoing payments of child support, medical or dental expenses that is being paid by either parent if applicable.

☐ Verification of payments made, 3 months prior to the month of application, if legally obligated to pay

☐ Verification of payment made for 2 months prior to application for medical or dental payments

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Verification of child custody: if the other parent is not part of your family, verification of custody is needed to include the days and times each parent will have custody.

☐ A current court order; or

☐ Affidavit or legal statement

☐ If none of the above, provided a written statement from the other parent

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Signatures: Both parents on the application are required to sign the Statement of Truth, Rights and Responsibilities and Authorization for Release of Information with their actual signature.
Electronic signatures are not allowed.

☐ Signature of Parent 1

☐ Signature of Parent 2

Additional important information you need to know:

- Regulations require the agency to send you a written notice on approval, denials, changes made to your case, or the need for additional information and verification.
- The agency is not required to send you an email or make a call to you requesting information.
- Read your mail so you don't miss providing information by the due dates in notices.
- Read your rights and responsibilities, there is no leeway in the regulations when you report untimely.
- Look at all documents you receive from the agency to be sure they are accurate. If the agency makes an error, you must let the agency know right away or you may need to repay benefits.
- Regardless of whether you or the agency makes an error on your case, you will be required to re-pay any overpayment of benefits. The agency will correct any underpayment of benefit errors.

Child Care Assistance Application

PLEASE PRINT CLEARLY

Use the checklist provided above for verification needed with this application.

List the parents who are applying for Child Care Assistance: List all parents who are in the home.			
Full Name of Family's Parent (First, Middle, Last):			
Maiden Name and all aliases:			
Full Name of Family's Second Parent (First, Middle, Last):			
Maiden Name and all aliases for the second parent:			
Marital Status:			
Home Address	City	State	Zip Code
Mailing Address	City	State	Zip Code
☐ I consider myself Homeless. The above addresses are for contact information only.			
Home Telephone:	Cell Phone:	Work Phone:	
Email address where the program can send broadcast notifications:			

Family's Primary Language, Select only One:

☐English
☐Spanish
☐Native Central, South American, and Mexican Languages (e.g., Mixteco, Quichean)
☐Caribbean Languages (e.g., Haitian-Creole, Patois),
☐Middle Eastern and South Asian Languages (e.g., Arabic, Hebrew, Hindi, Urdu, Bengali)
☐East Asian languages (e.g., Chinese, Vietnamese, Tagalog)
☐Native North American/Alaska Native Languages
☐Pacific Island Languages (e.g., Palauan, Fijian)
☐European and Slavic Languages (e.g., German, French, Italian, Croatian, Yiddish, Portuguese, Russian)
☐African Languages (e.g., Swahili, Wolof)
☐Other (e.g. American Sign Language):

Military: Is either parent of the family active duty in any branch of the United States Military?	☐Yes or ☐No
or Reserve/National Guard	☐Yes or ☐No
Housing: Is either parent receiving a voucher or cash towards?	☐Yes or ☐No
Federal cash income: Is either parent receiving other federal cash income?	☐ Yes or ☐No
Family Assets: Does your family have combined assets totaling more than $1,000,000.00. Assets include but are not limited to items of ownership convertible into cash; such as notes, accounts, securities, or real estate.	☐Yes or ☐No

Use Page 9 or an extra piece of paper to provide additional information so the agency has the most accurate information regarding your family.

List all people who are part of your family: Attach verification of age and citizenship for each child needing child care. Use a separate sheet or page 9 of this application if needed.
Parent 1 (First, Middle, Last):
Relationship to you: **SELF**
Date of Birth MM/ DD/ YY:
Social Security Number (optional):
Gender: ☐Male or ☐Female U.S. Citizen: ☐Yes or ☐No Hispanic/Latino ethnicity: ☐ Yes or ☐ No Race: ☐ American Indian ☐Alaskan Native ☐White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

Parent 2 (First, Middle, Last):
Relationship to you: **2nd Parent if residing in the home**
Date of Birth MM/ DD/ YY:
Social Security Number (optional):
Gender: ☐Male or ☐Female U.S. Citizen: ☐Yes or ☐No Hispanic/Latino ethnicity: ☐ Yes or ☐ No Race: ☐ American Indian ☐Alaskan Native ☐White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

Family Member Name (First, Middle, Last):
Relationship to you:
Date of Birth MM/ DD/ YY:
Social Security Number (optional):
Does this family member have special needs with a diagnosis by a health care professional. ☐Yes or ☐No Gender: ☐Male or ☐Female U.S. Citizen: ☐Yes or ☐No Hispanic/Latino ethnicity: ☐ Yes or ☐ No Race: ☐ American Indian ☐Alaskan Native ☐White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

Continued… List all people who are part of your family: Attach verification of age and citizenship for each child needing child care. Use page 9 for more space.

Family Member Name (First, Middle, Last):

Relationship to you:

Date of Birth MM/ DD/ YY:

Social Security Number (optional):

Does this family member have special needs with a diagnosis by a health care professional. ☐Yes or ☐No
Gender: ☐Male or ☐Female
U.S. Citizen: ☐Yes or ☐No
Hispanic/Latino ethnicity: ☐ Yes or ☐ No
Race: ☐ American Indian ☐Alaskan Native ☐White ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander

Family Member Name (First, Middle, Last):

Relationship to you:

Date of Birth MM/ DD/ YY:

Social Security Number (optional):

Does this family member have special needs with a diagnosis by a health care professional. ☐Yes or ☐No
Gender: ☐Male or ☐Female
U.S. Citizen: ☐Yes or ☐No
Hispanic/Latino ethnicity: ☐ Yes or ☐ No
Race: ☐ American Indian ☐Alaskan Native ☐White ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander

Family Member Name (First, Middle, Last):

Relationship to you:

Date of Birth MM/ DD/ YY:

Social Security Number (optional):

Does this family member have special needs with a diagnosis by a health care professional. ☐Yes or ☐No
Gender: ☐Male or ☐Female
U.S. Citizen: ☐Yes or ☐No
Hispanic/Latino ethnicity: ☐ Yes or ☐ No
Race: ☐ American Indian ☐Alaskan Native ☐White ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander

Earned Income: Does either parent work for an employer? ☐Yes or ☐No If Yes, list **all** jobs for both parents listed on this application and attach verification. Use page 9 for more space.

Family Member Name (First, Middle, Last):

Employer Name, City, Phone Number:

With this employer I receive or will receive: ☐ Regular wages ☐ Bonuses ☐ Commission ☐ Tips

Start Date (MM/DD/ YY): _____ Hourly Wage:$ _____

I work: ☐ The same schedule every week ☐ A varied schedule ☐ On call ☐ Over time

My typical work schedule is: Check all days you work and add times including am and/or pm

☐ Monday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Tuesday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Wednesday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Thursday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Friday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Saturday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Sunday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm

I receive regular gross wages in the amount of $_____ (before taxes)

☐ Weekly ☐ Every 2 weeks (example: paid every other Friday)

☐ Monthly ☐ 2 times per month (example: paid 5th and the 20th) ☐ End of the season

I receive Commission in the amount of $_____

☐ With my regular pay ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Yearly ☐ Other_____

I receive Bonuses in the amount of $_____

☐ With my regular pay ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Yearly ☐ Other_____

I receive Tips in the amount of $_____ ☐ With my regular pay ☐ Weekly ☐ Monthly ☐Other_____

Family Member Name (First, Middle, Last):

Employer Name, City, Phone Number:

With this employer I receive or will receive: ☐ Regular wages ☐ Bonuses ☐ Commission ☐ Tips

Start Date (MM/DD/ YY): _____ Hourly Wage:$ _____

I work: ☐ The same schedule every week ☐ A varied schedule ☐ On call ☐ Over time

My typical work schedule is: Check all days you work and add times including am and/or pm

☐ Monday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Tuesday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Wednesday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Thursday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Friday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Saturday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm
☐ Sunday	Start time:_____	☐ am or	☐ pm	End Time:_____	☐ am or	☐ pm

I receive regular gross wages in the amount of $_____ (before taxes)

☐ Weekly ☐ Every 2 weeks (example: paid every other Friday)

☐ Monthly ☐ 2 times per month (example: paid 5th and the 20th) ☐ End of the season

I receive Commission in the amount of $_____

☐ With my regular pay ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Yearly ☐ Other_____

I receive Bonuses in the amount of $_____

☐ With my regular pay ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Yearly ☐ Other_____

I receive Tips in the amount of $_____ ☐ With my regular pay ☐ Weekly ☐ Monthly ☐Other_____

Unearned Income; Do you or anyone in your family receive money from any other source ☐Yes or ☐ No
If Yes, complete the information below and attach verification. Use page 9 for more space.

Family Member Name (First, Middle, Last) who is receiving the payment:

Check the box of unearned income received and provide the amount received and how often received:

☐ Adoption Payments: Amount: $_____ How often received:_____
☐ Alaska Native Claims Settlement Act: Amount: $_____ How often received:_____
☐ Child Support: Amount: $_____ How often received:_____
☐ Employer paid housing/room and board: Amount: $_____ How often received:_____
☐ Foster Care Payments: Amount: $_____ How often received:_____
☐ Guardian Payments: Amount: $_____ How often received:_____
☐ Interest/Estate Payments/Royalties: Amount: $_____ How often received:_____
☐ Investments Income/Capital Gains: Amount: $_____ How often received:_____
☐ Military Cash Allowances: Amount: $_____ How often received:_____
☐ Native Corp. Distribution: Amount: $_____ How often received:_____
☐ Public Assistance Cash Program: Amount: $_____ How often received:_____
☐ Rental Income: Amount: $_____ How often received:_____
☐ Retirement/Pension Income: Amount: $_____ How often received:_____
☐ Social Security/Supplemental Income: Amount: $_____ How often received:_____
☐ Stipends: Amount: $_____ How often received:_____
☐ Unemployment Insurance Benefit: Amount: $_____ How often received:_____
☐ Veteran's Administration Payment: Amount: $_____ How often received:_____
☐ Workers Compensation: Amount: $_____ How often received:_____
☐ Other:_____ Amount: $_____ How often received:_____

Family Member Name (First, Middle, Last) who is receiving the payment:

Check the box of unearned income received and provide the amount received and how often received:

☐ Adoption Payments: Amount: $_____ How often received:_____
☐ Alaska Native Claims Settlement Act: Amount: $_____ How often received:_____
☐ Child Support: Amount: $_____ How often received:_____
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☐ Guardian Payments: Amount: $_____ How often received:_____
☐ Interest/Estate Payments/Royalties: Amount: $_____ How often received:_____
☐ Investments Income/Capital Gains: Amount: $_____ How often received:_____
☐ Military Cash Allowances: Amount: $_____ How often received:_____
☐ Native Corp. Distribution: Amount: $_____ How often received:_____
☐ Public Assistance Cash Program: Amount: $_____ How often received:_____
☐ Rental Income: Amount: $_____ How often received:_____
☐ Retirement/Pension Income: Amount: $_____ How often received:_____
☐ Social Security/Supplemental Income: Amount: $_____ How often received:_____
☐ Stipends: Amount: $_____ How often received:_____
☐ Unemployment Insurance Benefit: Amount: $_____ How often received:_____
☐ Veteran's Administration Payment: Amount: $_____ How often received:_____
☐ Workers Compensation: Amount: $_____ How often received:_____
☐ Other:_____ Amount: $_____ How often received:_____

Self-Employment: Is either parent self employed? ☐Yes or ☐No If Yes, complete the information below and attach verification. Use page 9 for more space.

Family Member Name (First, Middle, Last):

Name of and Type of Business:

Is your business ☐ Year-round Activity or ☐ Seasonal – List the months you work: _____

My typical work schedule is: Check all days you work and add work times including am and/or pm.

☐ Monday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Tuesday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Wednesday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Thursday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Friday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Saturday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Sunday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm

Business Income for the three months prior to the month of application submission: $_____

Business Expenses for the three months prior to the month of application submission: $_____

Family Member Name (First, Middle, Last):

Name of and Type of Business:

Is your business ☐ Year-round Activity or ☐ Seasonal – List the months you work: _____

My typical work schedule is: Check all days you work and add work times including am and/or pm.

☐ Monday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Tuesday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Wednesday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Thursday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Friday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Saturday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Sunday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm

Business Income for the three months prior to the month of application submission: $_____

Business Expenses for the three months prior to the month of application submission: $_____

Education or Training Program: Does either parent in your family attend a job training or educational program? ☐ Yes or ☐ No If Yes, complete the information below and attach verification.

Name of person attending education/training (First, Middle, Last):

Name of the Education/Training institution:

Start Date: End Date:

Financial aid: $_____

Class Schedule: Check all days you attend class and add class times including am and/or pm.

☐ Monday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Tuesday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Wednesday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Thursday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Friday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Saturday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm
☐ Sunday	Start time:_____	☐ am or ☐ pm	End Time:_____	☐ am or ☐ pm

Continued… Education or Training Program: Use page 9 for more space.
Name of person attending education/training (First, Middle, Last):
Name of the Education/Training institution:
Start Date: End Date:
Financial Aid: $_____
Class Schedule: Check all days you attend class and add class times including am and/or pm
☐ Monday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm
☐ Tuesday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm
☐ Wednesday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm
☐ Thursday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm
☐ Friday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm
☐ Saturday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm
☐ Sunday Start time:_____ ☐ am or ☐ pm End Time:_____ ☐ am or ☐ pm

Deductible Child Support Expenses. Does either parent in your family pay child support to someone outside of the home? ☐ Yes or ☐ No If Yes, complete the information below and attach verification.
Name of person paying child support:
Monthly amount paid: $
Name of person paying child support:
Monthly amount paid: $

Deductible Catastrophic Medical/Dental Expenses. Does either parent pay catastrophic medical or dental expenses that total more than 10% of the family's monthly gross income, that you have made payments on for more than 60 days and are projected to be an ongoing monthly expense for more than 6 months? ☐ Yes or ☐ No If Yes, complete the information below and attach verification.
Name of person paying catastrophic medical or dental expenses:
Monthly amount paid: $
Name of person paying catastrophic medical or dental expenses:
Monthly amount paid: $

Child Custody: Is there a custody arrangement for children needing child care? ☐ Yes or ☐ No If Yes, complete the information below and attach verification of custody. Use page 9 for more space.
Child(ren) Name(s):
List your custody schedule along with drop off/pick up times:
This is a court order custody arrangement: ☐ Yes or ☐ No

Child(ren) Name(s):
List your custody schedule along with drop off/pick up times:
This is a court order custody arrangement: ☐ Yes or ☐ No

Child(ren) Name(s):
List your custody schedule along with drop off/pick up times:
This is a court order custody arrangement: ☐ Yes or ☐ No

Child's School Schedule: I have children who attend or will attend school next year: ☐ Yes or ☐ No If Yes, complete the information below for each child in school or who will attend school next year.
Child's Name (First, Middle, Last)
Name of the School, Pre-Elementary School, Early Head Start, or Head Start program:
Days and Times school is in session:
How does each child get to and from school:
List the time the child leaves and returns to provider: Leaves at: _____ ☐am or ☐ pm Returns at: _____ ☐ am or ☐ pm
Full day child care is needed for Inservice /School closures ☐ Yes or ☐ No

Child's Name (First, Middle, Last)
Name of the School, Pre-Elementary School, Early Head Start, or Head Start program:
Days and Times school is in session:
How does each child get to and from school:
List the time the child leaves and returns to provider: Leaves at: _____ ☐am or ☐ pm Returns at: _____ ☐ am or ☐ pm
Full day child care is needed for Inservice /School closures ☐ Yes or ☐ No

Child Care Needs: List all children and the child care provider you will be using. Use Page 9 for more space. **Definitions:** **The Primary Child Care provider** is your main provider and cares for the child(ren) the most amount of time. **The Secondary Child Care provider** is the provider you use to fill in the times the primary provider cannot care for the child(ren).
Child's Name (First, Middle, Last)
My Primary (main) Child Care Provider Name / Address: Uiviilat Play and Learn Center P.O. Box 948 Nome, AK 99762
This child has already started child care with this provider: ☐ Yes or ☐ No If yes, start date?
Days and times child care is needed with the primary provider:
My Secondary Child Care Provider Name / Address:
This child has not started with this provider and is on a waitlist: ☐ Yes or ☐ No If no, provide additional information:
Days and times child care is needed with the secondary provider:

Child's Name (First, Middle, Last)
My Primary (main) Child Care Provider Name / Address: Uiviilat Play and Learn Center P.O. Box 948 Nome, AK 99762
This child has already started child care with this provider: ☐ Yes or ☐ No If yes, start date?
Days and times child care is needed with the primary provider:
My Secondary Child Care Provider Name / Address:
This child has not started with this provider and is on a waitlist: ☐ Yes or ☐ No If no, provide additional information:
Days and times child care is needed with the secondary provider:

Continued… Child Care Needs: Use page 9 for more space.
Child's Name (First, Middle, Last)
My Primary (main) Child Care Provider Name / Address: Uiviilat Play and Learn Center P.O. Box 948 Nome, AK 99762
This child has already started child care with this provider: ☐ Yes or ☐ No If yes, start date?
Days and times child care is needed with the primary provider:
My Secondary Child Care Provider Name / Address:
This child has not started with this provider and is on a waitlist: ☐ Yes or ☐ No If no, provide additional information:
Days and times child care is needed with the secondary provider:

Child's Name (First, Middle, Last)
My Primary (main) Child Care Provider Name / Address: Uiviilat Play and Learn Center P.O. Box 948 Nome, AK 99762
This child has already started child care with this provider: ☐ Yes or ☐ No If yes, start date?
Days and times child care is needed with the primary provider:
My Secondary Child Care Provider Name / Address:
This child has not started with this provider and is on a waitlist: ☐ Yes or ☐ No If no, provide additional information:
Days and times child care is needed with the secondary provider:

Preferred Interview Day / Timeframe and Method: The parent listed at the top of Page 1 of this application is required to participate in an interview. Your preferred day/time will be honored whenever possible; ***Please provide more than one preferred day/time*** so your interview can be completed timely. An interview can take approximately 30 min to an hour.
Choose the best interview Method: ☐ Telephonic Interview or ☐ In-person Interview
Best day of the week and time to call you for the interview:

Use this space for any additional information or for section where there wasn't enough space:

Statement of Truth, Rights and Responsibilities and Authorization for Release of Information

Statement of Truth and Rights and Responsibilities

Under penalty of perjury or unsworn falsification, I certify that the statements made on this application and during my interview for assistance regarding the persons in my family, my family's income, participation in eligible activities, and all other items that pertain to my family's possible eligibility for Child Care Assistance Program benefits are true and correct to the best of my knowledge. I have read and kept a copy of the "Your Rights and Responsibilities" portion of this application and by signing below, agree to comply with the requirements for participation in the program and certify the statements are true.

Authorization For Release Of Information

I authorize the release of information requested by the Department of Health and Social Services, its designees, or its agents within the Department of Law. The requested information will only be used in the administration of the Child Care Assistance Program or other public assistance programs, 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.

This release of information will be in effect while I am an applicant or recipient of the Child Care Assistance Program or other public assistance programs, and for any later investigations pertaining to my eligibility and program benefits.

Persons or organizations that may be contacted include, but are not limited to: employers, landlords, school authorities, Alaska Departments of Law, Labor, Revenue, Public Safety, Fish & Game, Military and Veterans Affairs; Bureau of Citizenship and Services; Alaska Housing Finance Corporation; Social Security Administration; tax assessors; financial institutions; stock brokerage firms; local governments; public assistance program contractors and grantees; native corporations and private individuals.

I have read the definition of family and have included on this application everyone who is part of my family and reported all income and activities for every person in my family. **Must be your actual signature.**

_____	_____
Printed Name of Family's Parent	Printed Name of Family's Parent
_____	_____
Signature of Family's Parent (**Your actual signature**)	Signature of Family's Parent (**Your actual signature**)
_____	_____
Address	Address
_____	_____
Phone Number	Phone Number
_____	_____
Date	Date

A Copy of this Release is as Valid as the Original