Child Care Program Office
Division of Public Assistance
PO Box 241809
Anchorage, Alaska 99524-1809

Office Use Only

CHILD CARE GRANT
REIMBURSEMENT REQUEST FOR
STAFF SALARIES AND BENEFITS OR SUBSTITUTE CARE

Facility Name: _____ Phone: _____

Administrator Name (Printed):_____

Mailing Address: _____

City: _____ Zip Code: _____ ICCIS Number: _____

☐ Per 7 AAC 39.040(a) (1) the Child Care Grant Reimbursement Request for the service month of _____ was used for staff salaries and benefits for the individual staff member(s) listed below:

_____

_____

OR

☐ Per 7 AAC 39.040(a) (e) the Child Care Grant Reimbursement Request for the service month of _____ was used for providing substitute care for the days or timeframe of _____for the individual(s) listed below:

_____

_____

By signing below I certify under penalty of perjury all the information contained on this form is true and correct. I understand that if I provide false information on this or any other form submitted in relation to Child Care Grant payments, any money obtained as a result must be repaid and I may be subject to sanctions under 7 AAC 39.060.

_____
Printed Name

_____ _____
Signature of individual with CCG signing authority Date