CHILD CARE GRANT (CCG) REIMBURSEMENT REQUEST (MANUAL)
INSTRUCTIONS & FACILTIY RESPONSIBILITIES

This form must be completed by hand. To request an electronic copy of the form, please email the Child Care Program Office (CCPO) at ccpo@alaska.gov. For submission to the CCPO, see contact information on the front of this form. You must print clearly using ink. Illegible information may result in the return of your submission unpaid. If you make a mistake, you may legibly correct it using correction tape/fluid or eraser. Forms which have been altered in any way will not be accepted.

Due Date: CCG Reimbursement Request with the CCG Attendance Report Form(s) is due by the last day of the month following the month care was provided (Report Month). For Example: Report Month for April must be received or postmarked by May 31.

The following instructions are lettered or numbered to correspond to items on this form. Please note not completing the form in its entirety may cause delays in processing:

a. ICCIS #: This is the eight digit number beginning with 100 issued to you by the CCPO for your facility.
b. PVN#: This is your Pay Vendor Number issued by the State of Alaska Accounting System needed to release payments.
c. Facility Name: Name of your facility as it appears on your Child Care License.
d. Physical Location of Facility: The full street address where care was provided.
e. City [for Physical Location]: The city for the street address of your Physical Location.
f. Zip [for Physical Location]: This is zip code for the physical location identified in e. and f.
g. Mailing Address: The full street address or postal box where the State of Alaska payment is mailed.
   NOTE: for some businesses this may be different from the facility mailing address.
h. City [for Mailing Address]: The city for the mailing address identified in h.
i. Zip [for Mailing Address]: The zip code for the mailing address identified in h.
j. Has any of your facility information above changed?: Check the box if YES.
k. If YES [in k], contact licensing: Contact your licensing specialist to report your current information.
l. Report Month/Year: The month/year for which the expenditures and attendance were documented and reimbursement is requested.
1. Full-Time Equivalent (FTE) Children: Enter the grand total of all the FTEs for the report month by adding the FTE Page Totals from all the CCG Attendance Report Form(s).
2. Average Daily Attendance: After dividing Line 1 by 21.7 using a calculation to the 3rd decimal point, enter the figure to the 2nd decimal point by rounding: down when the 3rd decimal point is 0 to 4. For example: 15.134 = 15.13; or up when the 3rd decimal point is 5 to 9. For example: 15.157 = 15.16.
3. CCG Rate Schedule Geographic Rate: Enter the dollar amount from the CCG Rate Schedule for the city where the facility is physically located.
4. Maximum qualifying reimbursement amount: Multiple Line 2 by Line 3. This is the maximum eligible reimbursement amount.
5. CCPO USE ONLY: CCG reimbursement amount
6. Number of children with CCAP authorizations: Enter the total number of children in attendance during the report month authorized by the State of Alaska Child Care Assistance Program as documented on the CCG Attendance Report Form(s).
7. Number of all other children: Enter the total number of children in attendance during the report month that are "self-pay" as documented on the CCG Attendance Report Form(s).
8. Total children in care: Enter the total of all children in care during the report month (add lines 6 through 8) as documented on the CCG Attendance Report Form(s).
9. Attendance Minimum: Multiply Line 2 (Average Daily Attendance) by .05. Enter the next whole number if it is more than 1; for example, enter "2" if the number is 1.14. If the number is less than 1, enter "1". This is the required number of children your facility must maintain with a CCAP to maintain compliance with the CCG Program.
10. Child Care Grant Fund Expenditures: Check each expenditure category CCG funds were used for during the report month. For each expenditure category checked, enter the dollar amount spent. For items that are purchased, atttach a legible copy of your receipt that shows the item and date of purchase, or the CCG Reimbursement Request for Staff Salaries and Benefits or Substitute Care form to support the amount spent. . **NOTE:** If the Total for all expenditures is more than the amount in Line 4 you will only be reimbursed the maximum qualifying reimbursement amount in Line 4.
11. **Signature Block**: The individual with signatory authority printed name, signature, contact telephone number and the date the form was signed.