CHILD CARE PROGRAM OFFICE
3601 C St, Ste # 140
Anchorage, AK 99503
Phone: (907) 269-4500 Toll Free: (888) 268-4632

For Office Use Only

CHILD CARE GRANT (CCG) REIMBURSEMENT REQUEST (Manual)

ICCIS #:[a] PVN #:[b]
Facility Name:[c]
Physical Location of Facility:[d]
City:[e] Zip:[f]
Mailing Address:[g]
City:[h] Zip:[i]
Has any information above changed?:[j] ☐ YES **If YES, contact licensing**[k]

Report Month/Year:[l] /

6. Number of children with CCAP authorizations (C)
7. Number of children for Self Pay (S)
8. Total children in care (total of Lines 6 through 8)
9. ATTENDANCE MINIMUM:

1. Write the number of full-time equivalent children in care for the report month:
2. Divide **Line 1** by 21.7 (Average Daily Attendance):
3. Enter the geographically adjusted rate for your community from the Child Care Grant Rate Schedule:
4. Multiply **Line 2** by **Line 3**. This is your maximum qualifying reimbursement amount: $
5. CCPO USE ONLY: CCG reimbursement amount approved for payment and supported by attached receipts. $

10. Specify how Child Care Grant Funds were spent during the report month *(check all that apply and enter amount):*

Expenditure Category	Amount ($)
☐ Staff salaries & benefits	$
☐ Substitute care, cost associated with providing	$
☐ Supplies, equipment & activities costs for children	$
☐ Health & safety costs	$
☐ Child development education & training for staff	$
☐ OTHER: Requires CCPO Pre-approval	$

Total is supported by attached receipts or attached documentation and may not exceed the maximum qualifying reimbursement amount in **Line 4**.

Total $

[11] **STATEMENT OF TRUTH:** Under penalty of perjury or unsworn falsification, I certify that the information provided on this form and all accompanying daily CCG Attendance forms for the period indicated are true and accurate. I understand that if I provide false information on or with this form, any money obtained as a result must be paid back to the State of Alaska and I may not be able to participate in the Child Care Grant Program in the future. **I understand that this payment request must be received by the last day of the month following the report month or payment will be denied.**

Printed Name of Individual With Signatory Authority | Signature of Individual With Signatory Authority | Contact Telephone Number | Date ____/____/_____

CCPO ACCOUNTING USE ONLY: **Approved for Payment Signature:** _____ **Date:** ____/____/_____ **CODING:**