State of Alaska
Department of Health and Social Services
Division of Public Assistance
Child Care Program Office
http://dhss.alaska.gov/dpa/Pages/ccare/default.aspx

Child Care Assistance Application Checklist

✓ Check to be sure you have submitted the following documents. To reduce processing time and avoid delays please be sure all applicable items listed below are submitted with the completed application. **Detach checklist and keep for your records.**

- ☐ The completed and signed application. Parent and spouse or both parents in the family must sign the application.
- ☐ A copy of your government issued photo identification (for each parent or spouse on the application).
  - ☐ My photo ID is on file with the CCA office.
  - ☐ Other parent/spouse's photo ID is on file with the CCA office.
- ☐ Proof of age for each child who will be receiving child care. (This can be copies of birth certificates, hospital birth records, shot records)
  - ☐ Age verification is on file with the CCA office for all children needing child care assistance.
- ☐ Proof of alien status for each child who will be receiving child care assistance, if not a U.S. citizen.
  - ☐ Alien status verification is on file with the CCA office for all children needing child care assistance.
- ☐ Proof of child custody, if applicable. (This can be court order, affidavit or statement)
  - ☐ Current court documents are on file with the CCA office for all children needing child care assistance.

Eligible activity for each parent or spouse on the application:

- ☐ A copy of your current and/or future school schedule showing classes you are registered to attend with the school name or school name and hours if attending high school.
- ☐ Proof of current and/or future financial aid / account summary by term, for money received for college.

Gross Earned income for each parent and or spouse on the application:

- ☐ Proof of all earned income received in the two most current months by each parent/spouse on the application. (This can be your two most current paystubs or employment verification letter from your employer)

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

- ☐ A copy of current State of Alaska business license;
- ☐ A copy of your most recently completed Federal tax return with schedule C; income and expense records; or other documentation of adjusted gross income and allowable costs of doing business. Three months of income and expense records are preferred to make a more accurate determination.

Unearned income for ALL members of your family:

- ☐ Proof of unearned income for all members of your family. Unearned income includes but is not limited to: dividends and interest, payments from Child Support, Social Security, Supplemental Security Income (SSI) and Native Corporations. Please refer to unearned income section on page 3 of the Application.
  - ☐ Alimony
  - ☐ Child Support
  - ☐ Foster Care Payments
  - ☐ Native Corp. Disbursements
  - ☐ Social Security
  - ☐ Supplemental Security Income
  - ☐ Unemployment

Possible deductions:

- ☐ Proof of ongoing medical or dental payments, if applicable See page 3 of application.
- ☐ Proof of child support you are legally obligated to pay and are paying, if applicable.

Return the completed application with all documents to:

If faxing, be sure to fax both sides of each page.

Child Care Assistance Program General Information

Who do I contact if I need help filling out the application or have questions?

If you have questions or need assistance in completing your application, please contact your local child care assistance office (noted at the bottom of the previous page).

When do benefits begin if I am determined eligible?

If eligible, benefits will begin the date you submitted your signed application as long as all the required documentation is received within 30 days.

Is an interview required?

Yes. An interview is required 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.

Once I am determined eligible, what do I need to do to maintain my eligibility?

You must notify your local child care assistance office of any changes in your income and/or family within 10 calendar days of when the change occurred. You must also submit a new application with all of the required documentation and complete an interview before your eligibility expires.

Will I have to pay anything?

Yes. You will have a monthly family contribution amount depending on your income and family size. This is called a co-pay. Your provider may also charge more than the Child Care Assistance Program pays. Each month you will have to pay your provider the co-pay amount and the difference, if any, between what the provider charges and what the state pays.

How much can I make and still qualify?

Financial eligibility is based on the total monthly income (earned and unearned) by family size. This also determines the family's contribution (co-pay).

Family Size	Maximum Total Monthly Income	Maximum Co-pay Amount
2	4250	425
3	4524	452
4	4614	461
5	5045	505
6	5477	548
Income limits and family contribution for families larger than six are available at: http://www.hss.state.ak.us/dpa/programs/ccare/default.aspx		

Which child care provider(s) can I use?

Child care providers must also apply to participate in the Child Care Assistance Program. A provider cannot receive State funding until they are approved or licensed. The Child Care Resource and Referral agency that serves your community can help you get a list of participating providers in your area.

Who is considered part of my family?

The following descriptions of family are for Child Care Assistance Program purposes only.

- To be considered part of your family, ***all members must live in the same home.***
- Of the people living in your home, your family includes: ***yourself, your spouse and each of your children who are under 18 years of age.***
- You may also have children living in your home who are not biologically yours. ***If you are their guardian and have financial responsibility for them***, they are counted as part of your family.
- If you are not married, but ***the other parent of any of your children lives in your home***, he or she and his or her children are considered part of your family.
- If you are not married but are living in the same home with another adult who has children of their own, and you have no children in common, he or she and his or her children are not considered part of your family. In this case each parent may apply to receive child care assistance for their own children.

Child Care Assistance Application

PLEASE PRINT CLEARLY

For Office Use Only Date Received	
GREEN	RED

Who is the family's Responsible Party? This is the person who is requesting Child Care Assistance and assumes responsibility for compliance with program rules and requirements, including penalties and repayment of any overpaid benefits.

Full Name of family's Responsible Party (First, Middle, Last)	Maiden Name, if any	Social Security Number (Optional)	
Home Address	City	State **AK**	Zip Code
Mailing Address	City	State **AK**	Zip Code
☐ Homeless. The above addresses are for contact information only.			
Home Telephone	Work Telephone(s)	Cell Telephone	E-mail
Marital Status	Other Names You Have Used		

Who is Considered Part of My Family? List each person in your family starting with yourself. See definition of family on Page 2 of the application checklist. You will need to provide a copy of the alien identification card (front and back) for each child who is not a U.S. citizen. If more space is needed, you may use a separate sheet or Page 6 of this application.

Family Members (First, Middle, Last)	Relationship to you	Date of Birth MM/DD/YY	Social Security Number (optional)	Special Needs (as defined by 7AAC 57.940)	Gender U.S. Citizen	Ethnicity (Use codes below)	Race (Use codes below)
	SELF			☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI
				☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI
				☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI
				☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI
				☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI
				☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI
				☐ Yes ☐ No	☐ M ☐ F U.S. Citizen ☐Yes ☐No	☐ Yes ☐ No	☐AN ☐AI ☐AS ☐BL ☐WH ☐PI

Ethnicity: **Y** = Hispanic or Latino
N = Not Hispanic or Latino

Race (you may select more than one):
AN = Alaskan Native **WH** = White **BL** = Black or African American
AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander

Housing Assistance. Do you receive a housing voucher or cash assistance for housing? ☐ Yes ☐ No
(Mark "No" if living on a military installation)

Work Activity / Earned Income in Your Family. Include gross wages, salary, tips, bonuses and commissions, from all jobs received or that is expected to be received for all the adults in your family. (See definition of family on Page 2 of the application checklist). Attach proof of employment, wages and earnings for the two most current months.

Family Member Name (First, Middle, Last)	Employer Name & City	# of Hours Worked/ Week	Start Date (MM/DD/YY)	Work Schedule to include the times of day and days of the week	Hourly Wage	How Often are you Paid?
						☐Weekly ☐Twice a month ☐Every 2 weeks ☐Monthly ☐Other:______
						☐Weekly ☐Twice a month ☐Every 2 weeks ☐Monthly ☐Other:______
						☐Weekly ☐Twice a month ☐Every 2 weeks ☐Monthly ☐Other:______
						☐Weekly ☐Twice a month ☐Every 2 weeks ☐Monthly ☐Other:______

Preferred Interview Day / Timeframe and Method: ☐ **Telephonic** ☐ **In-Person at CCA Office**

Day(s) of the week preferred:	**Best time of the day:**

Other Eligible Activities. This includes seeking work and participating in an approved education or training program. Attach proof of course enrollment and financial aid account summary if activity is education.

Name of Person in Activity	Type of Activity ☐ Seeking Work ☐ Training/Education	Name of Training/ Educational Institution	Start Date (MM/DD/YY)	End Date (MM/DD/YY)
List the days and times you expect to participate in each activity. If your schedule varies, please explain:				
Total anticipated hours of all activities:				

Name of Person in Activity	Type of Activity ☐ Seeking Work ☐ Training/Education	Name of Training/ Educational Institution	Start Date (MM/DD/YY)	End Date (MM/DD/YY)
List the days and times you expect to participate in each activity. If your schedule varies, please explain:				
Total anticipated hours of all activities:				

Deductible Child Support Expenses. Only legally obligated child support payments may qualify. Attach proof of obligation and payments.

Does anyone in your family pay child support to someone outside of the home? ☐ Yes ☐ No

If yes, name of person paying child support: ______________________________Monthly amount: $_________________

Self-Employment. Include money received from all self-employment for all adults in your family engaged in self employment activities. Please attach proof of earnings and expenses or your previous year's tax return with Schedule C and a copy of your current State of Alaska business license.

Family Member Name (First, Middle, Last)	Type of Business	Seasonal (S) or Year-round (Y) Activity?	Business Income- Last three months preferred	Business Expenses- Last three months preferred
		☐ S ☐ Y		
		☐ S ☐ Y		

Unearned Income. Do you or **anyone in your family receive money from any other source (unearned income)?** ☐ Yes ☐ No

List any other money you or anyone in your family receives other than earned income or self employment and **attach proof** for each type of unearned income received. The Alaska Permanent Fund Dividend is not counted for any member of your family.

Name of Person Receiving Unearned Income (First, Middle, Last)	Source of Unearned Income Amount Received / Frequency Received (example: weekly, bi-weekly, monthly…)
	☐ Child Support $________/how often_______ ☐ ATAP $________/how often_______ ☐ Native Corp. Distribution $________/how often_______ ☐ SSA/SSI $________/how often_______ ☐ Education Financial Aid $________/how often_______ ☐ UIB $________/how often_______ ☐ Adoption Payments $________/how often_______ ☐ VA $________/how often_______ ☐ Foster care payment $________/how often_______ ☐ Guardian $________/how often_______ ☐ Other:______________ $________/how often_______
	☐ Child Support $________/how often_______ ☐ ATAP $________/how often_______ ☐ Native Corp. Distribution $________/how often_______ ☐ SSA/SSI $________/how often_______ ☐ Education Financial Aid $________/how often_______ ☐ UIB $________/how often_______ ☐ Adoption Payments $________/how often_______ ☐ VA $________/how often_______ ☐ Foster care payment $________/how often_______ ☐ Guardian $________/how often_______ ☐ Other:______________ $________/how often_______
	☐ Child Support $________/how often_______ ☐ ATAP $________/how often_______ ☐ Native Corp. Distribution $________/how often_______ ☐ SSA/SSI $________/how often_______ ☐ Education Financial Aid $________/how often_______ ☐ UIB $________/how often_______ ☐ Adoption Payments $________/how often_______ ☐ VA $________/how often_______ ☐ Foster care payment $________/how often_______ ☐ Guardian $________/how often_______ ☐ Other:______________ $________/how often_______
	☐ Child Support $________/how often_______ ☐ ATAP $________/how often_______ ☐ Native Corp. Distribution $________/how often_______ ☐ SSA/SSI $________/how often_______ ☐ Education Financial Aid $________/how often_______ ☐ UIB $________/how often_______ ☐ Adoption Payments $________/how often_______ ☐ VA $________/how often_______ ☐ Foster care payment $________/how often_______ ☐ Guardian $________/how often_______ ☐ Other:______________ $________/how often_______

ATAP = Alaska Temporary Assistance Program
SSA/SSI = Social Security Administration / Supplemental Income
UIB= Unemployment Insurance Benefit
VA= Veteran's Administration

Family Assets. Assets include but are not limited to: items of ownership convertible into cash; notes and accounts receivable, securities, or real estate. Does your family have combined assets totaling more than $1,000,000.00? ☐ Yes ☐ No

Deductible catastrophic medical or dental payments. Attach proof if you answer yes to the question below.

Does your family have medical or dental payments that exceed 10% of the family's gross monthly income; payments have been made for more than 60 days and are projected to be an ongoing expense for more than six months? ☐ Yes ☐ No

Child Custody Arrangement. Your arrangement can be either court ordered or informally agreed upon. Attach the child custody arrangement portion of your court order, if applicable. An affidavit or written statement must be submitted if informally agreed upon.

Child's Name (First, Middle, Last)	Days and times child is with you. Please indicate drop off/pick up times.	Court ordered
		☐ Yes ☐ No
		☐ Yes ☐ No

Child's School Schedule. To determine the unit of care needed for school aged children tell us your child's school information.

Child's Name (First, Middle, Last)	Name of Elementary School, Pre-Elementary School, Early Head Start, or Head Start program each child attends and the child's grade		Days and Times school is in session	How does each child get to and from school
	School Name	Grade		
	School Name	Grade		
	School Name	Grade		
	School Name	Grade		
	School Name	Grade		
	School Name	Grade		

Child Care Needs. Based on parent activities, custody/visitation and children's school schedules listed on the previous pages, tell us when each child will need care. The provider you select must be either Licensed or Approved to participate in the Child Care Assistance Program, by the State of Alaska or local designee, before any benefit will be paid on your behalf.

Child's Name (First, Middle, Last)	Days and Times Child Care Needed	Primary Child Care Provider Name / Address	Secondary Child Care Provider Name / Address

In-Home Provider Information.

Under limited circumstances, outlined in 7 AAC 41.370, you may select an individual to provide child care services in your home. <u>You are considered the employer and are required to complete an additional application.</u> You are responsible for compliance with all labor and IRS laws and requirements. There may be a lapse in eligible coverage as approval for in-home caregivers is based on the dates all required documents are submitted or completed regarding the caregiver and may not be the same date the family's eligibility may begin. This may require you to pay your caregiver out-of-pocket for child care. These costs will not be covered by this program.

☐ Child care will be provided in <u>my own</u> home (In-Home Care) by (caregiver's name): ______________________________

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

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 "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 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.

Printed Name of Family's Responsible Party	Printed Name of Other Adult Applicant
Signature of Family's Responsible Party	Signature of Other Adult Applicant
Address	Address
Phone Number	Phone Number
Date	Date

A Copy of this Release is as Valid as the Original.

Use this space for any additional information:

Your Rights and Responsibilities

The information on this page is based on State Regulations 7 AAC 41 – Child Care Assistance Program

Your Responsibilities

As a participant in the Child Care Assistance Program you must report any changes in your circumstances that may affect your family's eligibility for the Child Care Assistance Program within ten (10) calendar days of when you know of the change. You must report the following to your local child care assistance office:

- Changes in employment for any adult family member, such as starting or stopping a job, changes from part-time to full-time or full-time to part-time;
- Changes in your family size (see definition of family on page 2 of this application);
- If you move or get a new mailing address;
- Changes in any family member's legal obligation to pay child support;
- Changes in income in excess of $200 a month, or any other change that would affect your family's program benefits or eligibility; and
- When you need care authorized to a secondary child care provider.

You must also:

- Give your child care provider at least 14 days written notice of your family's intent to terminate child care except:
    - In the case of sudden program ineligibility;
    - In the case of an allegation of abuse, harm, or serious risk of harm to a child in the provider's care; or
    - Upon written mutual agreement signed by the provider and yourself;
- Pay your child care provider the difference between what your provider charges and what is paid on your behalf;
- Pay your child care provider your monthly co-pay amount;
- Renew your child care assistance participation in a manner timely enough to ensure eligibility is determined to continue coverage with your selected provider; and
- If requested by the Department, review the provider's monthly billing statement to verify that care was billed for the hours that care was provided.

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.

Administrative Reviews

If you disagree with a determination made by the local child care assistance office, you may request an administrative review and/or a hearing of the determination by the Department of Health and Social Services, Child Care Program Office. You may do this by submitting the *Request for Appeal* form, along with all required documentation within the prescribed timeframe for the type of appeal selected. Send your request to the: Child Care Program Office, 3601 C Street, Suite 140, P.O. Box 241809, Anchorage, AK 99524-1809 or Fax to: (907) 269-1064 or Toll Free:1 (888) 224-4536

Fair Hearing Request

If you disagree with a decision made by the local child care assistance office or on the decision on a request for an administrative review made by the Child Care Program Office, 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 by a responsible person acting on your behalf. The request must be submitted in writing within 30 calendar days of the date you receive the decision with which you are in disagreement. At the hearing you may represent yourself or be represented by a legal representative, friend or relative. 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.

You may continue to receive Child Care Assistance Program benefits until a hearing decision is made. If the hearing decision is not in your favor you may 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 Child Care Assistance 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.

Participation Requirements

To receive Child Care Assistance benefits, you must be participating in an eligible activity. In two-parent households both parents must be participating in an eligible activity, unless one parent is determined by a health care or mental health care professional to be incapacitated. Eligible activities include working, seeking work, and participating in an education or training program with the intent of improving your employability.

Fraud Penalty Warnings

Intentional Program Violation

You may be prosecuted or otherwise sanctioned if you knowingly give false, incorrect or incomplete information to try to get Child Care Assistance Program benefits you are not eligible for, or to help someone else get benefits to which they are not eligible. If you are found to have committed an intentional program violation or are convicted of defrauding the Child Care Assistance Program, 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.

Sanctions for Non-Compliance

Your participation in the Child Care Assistance Program may be suspended or terminated for any of the following reasons:

- Failing to report complete, accurate, and current information regarding family income and eligibility;
- Failing to keep family income and eligibility information current with the local child care assistance office;
- Failing to pay the family's co-pay amount of child care costs;
- Failing to comply with family responsibilities for participation in the program;
- Refusing to cooperate with a review or investigation by a representative of the Department or designee regarding eligibility for benefits or provision of services by a participating provider under the program; or
- Failing to comply with any compliance action or corrective action plan or to cooperate with the establishment of the plan.

If the Department determines that there is reasonable evidence of an overpayment of program benefits, the Department may take corrective action including: establishment of a repayment plan; program suspension for up to 6 months; or termination from the Program.

Overpayment of benefits means program benefits received by a family which the family was not entitled to or were received while the family was in non-compliance with a program requirement.

INCLUSIVE CHILD CARE PROGRAM
Division of Public Assistance
Child Care Program Office
3601 C Street, Suite 140
PO Box 241809, Anchorage, AK 99524-1809

Office Use Only

APPLICATION FOR ALASKA INCLUSIVE CHILD CARE

A child with special needs as described in 7 AAC 57.940 who is under 13 years of age may qualify for a supplemental program rate if the child's special needs are documented by a health professional; and the provider establishes, in consultation with the child care resource and referral agency assisting the family, that the child requires additional services due to the child's special needs, and that those services have an additional cost. Additional funding may be approved as a one-time payment or multiple payments depending on the child's specific needs and the additional cost for services and/or accommodations provided.

Printed Full Name of Family's Responsible Party (First, Middle, Last)			
Home Address	City	State **AK**	Zip Code
Mailing Address	City	State **AK**	Zip Code
Home Telephone	Work Telephone(s)	Cell Telephone	E-mail

Child's Name (First, Middle, Last)	Date of Birth:
Child's Name (First, Middle, Last)	Date of Birth:
Child's Name (First, Middle, Last)	Date of Birth:
Child's Name (First, Middle, Last)	Date of Birth:

Child Care Provider Name			**Contact Phone:**
Physical Address	**City**	**State** AK	**Zip Code**
Mailing Address	**City**	**State** AK	**Zip Code**

I understand I must be eligible to receive State of Alaska Child Care Assistance and Alaska Inclusive Child Care Programs in order for my child(ren)'s child care provider to receive supplemental funding.

Signature of Family's Responsible Party ______________________ Date ______________________

RELEASE OF INFORMATION

My signature below authorizes 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 Alaska Inclusive Child Care Program, and 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 Alaska Inclusive Child Care Program and for any investigation pertaining to my eligibility and/or program benefits.

Persons or organizations that may be contacted include, but are not limited to: physicians; health care professionals; mental health care professionals; child care providers; Alaska statewide Child Care Resource and Referral Network; individual service providers; schools; or other agencies identified as providing services to the child.

This authorization is valid for 12 months from the date it is signed. Each individual or agency listed will receive only the information pertaining to them to ensure confidentiality.

________________________________ __________________________
Signature of Family's Responsible Party Date

☐ Child Care Provider Name: ______________________________

Physical Address: ______________________________

Mailing Address: ______________________________

Contact Phone: ______________________________

☐ Health Care Professional Name: ______________________________

Physical Address: ______________________________

Mailing Address: ______________________________

Contact Phone Number: ______________________________

☐ School or Agency Providing Services

Name of School or other Agency: ______________________________

Name of Individual Contact Person: ______________________________

Physical Address: ______________________________

Mailing Address: ______________________________

Contact Phone: ______________________________