ALASKA INCLUSIVE CHILD CARE PROGRAM

Division of Public Assistance
Child Care Program Office
3601 C Street, Suite 140
Anchorage, AK 99503

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 year 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: _____

☐ School or Agency Providing Services

Name of School or other Agency:_____

Name of Individual Contact Person: _____

Physical Address: _____

Mailing Address: _____

Contact Phone: _____