CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office
http://dhss.alaska.gov/dpa/Pages/ccare

Office Use Only

CHILD CARE PROVIDER RATES AND RESPONSIBILITIES

Facility Name:_____ Contact Phone Number:_____

Physical Address:_____ City:_____ Zip:_____

Mailing Address:_____ City:_____ Zip:_____

Email address:_____

PROVIDER TYPE, CHECK ONLY ONE:

☐ Approved Relative

☐ Licensed by the State of Alaska ☐ Licensed by the Municipality of Anchorage

☐ Dept. of Defense Certified ☐ Coast Guard Certified

☐ Tribal Approved ☐ Tribal Certified

☐ Nationally Accredited Day Camp ☐ Nationally Certified Day Camp or similar Facility or Program

YOUR RATES, CHECK ONLY ONE: ☐ My rates are the same as the State rates adopted by reference under 7 AAC 41.025 (**do not complete the table below**) **OR** ☐ My rates are listed below (complete the charts)

Infant Birth through 12 months			**Toddler** 13 months through 35 months			**Preschool-Age** 36 months through 59 months			**School-Age** 5 years through 12 years		
	Full	Part		Full	Part		Full	Part		Full	Part
Month	_____	_____	Month	_____	_____	Month	_____	_____	Month	_____	_____
Day	_____	_____	Day	_____	_____	Day	_____	_____	Day	_____	_____

Note for CCAP purposes the following definitions apply: Full Month = 17 or more full days, Part Month = 17 or more part days, Full Day = 5 hours and 1 minute up to and including10 hours of care per day, and Part Day = Up to and including 5 hours of care per day.

REGISTRATION FEE: Registration fees will only be paid to Licensed, Department of Defense or Coast Guard Certified, or Nationally Accredited or Certified providers.

DO YOU CHARGE A REGISTRATION FEE? ☐ Yes ☐ No Registration Fee Amount $_____

Is your fee charged: ☐ Annually or ☐ One -Time and Charged by: ☐ Family or ☐ Child

CHILD CARE ASSISTANCE PROGRAM PROVIDER RESPONSIBILITIES

Your Responsibilities: As a provider participating in the Child Care Assistance Program (CCAP), I agree to respect and maintain the confidentiality of families participating in the CCAP and understand that I must not discriminate against such families on the basis of race, color, national origin, religion, sex, age, or handicap. As the owner of a child care facility, I assume the responsibility for remaining in compliance with the Child Care Assistance Program regulations 7 AAC 41, penalties, and repayment of any overpayments. I further understand that:

1. I must immediately notify my Child Care Licensing Specialist or the local child care assistance office regarding any circumstance that involves abuse, harm, or serious risk of harm to children in care, including the death or a serious injury or illness of a child while in care.
2. I must immediately notify the parent of a child in care of the death of a child in care, injury or illness of a child in care requiring attention by medical personnel outside of the child care facility and the exposure of a child to a contagious condition other than a cold.
3. The family I provide care for must also be determined eligible for CCAP participation and I must have a valid *Child Care Assistance Authorization* document for a month care was provided before I can request payment from the State of Alaska CCAP. Charges for services provided prior to either my approval or the family's approval for CCAP participation, or that are not on the *Child Care Assistance Authorization* document are the responsibility of the family and I understand cannot be billed to the State.
4. The rate charged to CCAP families must be the rate I have provided on the *Child Care Provider Rates and Responsibilities* CC12 form and may not be higher than the rate I charge non-CCAP families for the same service.
5. I must provide written notice of any rate changes to CCAP families and the appropriate child care assistance office at least 30 days before the effective date. New rates become effective the 1st day of the month following the thirty (30) day notice.
6. *Request for Payment* CC78 forms must be submitted by the last day of the month, following the month care services were provided and charges were incurred. Payment may be denied if submitted outside these timeframes.
7. I must give at least a 10 business day written notice of my intent to terminate services to CCAP families and the appropriate child care assistance office, except upon mutual written agreement between the family and myself.
8. I must maintain daily attendance records that reflect the dates and times children are in care.
9. I must maintain my status as a licensed, certified, or approved provider in order to receive CCAP payments.
10. I must retain all records required for participation and compliance with the CCAP for at least three years from the date of the record's creation. I will make these records available for inspection during normal business hours. Records required include but are not limited to:
    - All required state and local permits and/or licenses for operation of a child care business;
    - A copy of all rates and responsibilities forms;
    - A copy of all monthly child care requests for payment;
    - A copy of daily attendance records that reflect the dates and times children are in care;
    - Children's records including emergency information for each child;
    - Caregiver employment records; and
    - Documentation of emergency evacuation drills.
11. I must cooperate with the department by allowing announced or unannounced access by the department to all areas of the child care premises, records, and children in care for purposes of health and safety inspections, investigations, or other program compliance reviews.
12. I must report to the local child care assistance office any changes in circumstances that may affect program participation eligibility within 10 days after the change. A Licensed child care provider must report changes to their licensing specialist and the local child care assistance office.

INCORRECT PAYMENT OF PROGRAM BENEFITS

If you receive an overpayment of Public Assistance benefits or receive services to which you are not entitled, you may be financially responsible for repaying the overpayment or cost of services to the State of Alaska. This may be true even if the overpayment or improper authorization of services is due to an error on the part of the Department of Health and Social Services. By accepting payment of benefits or services, you must understand and agree that you may have a responsibility for the repayment of benefits or services to which you were not entitled.

INTENTIONAL PROGRAM VIOLATION

If you are found to have committed an intentional program violation by deliberately misrepresented, concealed or withheld a material fact resulting in a payment which you were not entitled, a penalty will be imposed up to and including disqualification from program participation and obligated to repay any amounts attributable to the intentional program violation or fraudulent act(s).

Under penalty of perjury or unsworn falsification, I certify that the information I have provided on this form is truthful and accurate and that I have read, or had read to me, and understand my responsibilities as described in this document. I have retained a copy of this document.

Printed Name of Owner/Authorized Agent	Signature of Owner/Authorized Agent	Date