



## CHILD CARE GRANT PROGRAM

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

Office Use Only

### REIMBURSEMENT REQUEST FOR STAFF SALARIES AND BENEFITS OR SUBSTITUTE CARE

Service Month: \_\_\_\_\_ ICCIS Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Per 7 AAC 39.040(a) (1) the funds requested through the Child Care Grant Program for reimbursement were used for staff salaries and benefits for the individual staff member(s) listed below:

\_\_\_\_\_  
\_\_\_\_\_

**OR**

Per 7 AAC 39.040(a) (2) the funds requested through the Child Care Grant Program for reimbursement were used for providing substitute care for the days or timeframe of \_\_\_\_\_ for the individual(s) listed below:

\_\_\_\_\_  
\_\_\_\_\_

By signing below I certify under penalty of perjury all the information contained on this form is true and correct. I understand that if I provide false information on this or any other form submitted in relation to Child Care Grant Program payments, any money obtained as a result must be repaid and I may be subject to sanctions under 7 AAC 39.060.

\_\_\_\_\_  
Printed Name of individual with CCG signing authority

\_\_\_\_\_  
Signature of individual with CCG signing authority

\_\_\_\_\_  
Date