CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

Office Use Only

CERTIFIED/ACCREDITED PROVIDER CHILD CARE ASSISTANCE APPLICATION

APPLICANT INFORMATION: This person is the owner of a United States Department of Defense or United States Coast Guard Certified, Tribally Approved or Certified, or Nationally Accredited or Certified Day Camp or similar child care facility. If the business owner is a corporation, the individual must have signing authority and provide verification of their authority.

Facility Name:_____

Owner Name:_____ Contact Phone: _____

Social Security Number or EIN:_____ ICCIS #:_____

Facility Physical Address:_____

Facility Mailing Address:_____

SIGNATORY AUTHORITY: The owner may authorize another individual associated with the facility signatory authority for completing and signing all Child Care Assistance Program forms, except a *Certified/Accredited Provider Child Care Assistance Application* CC84. An individual with signatory authority may not grant other individuals signatory authority. Facility Owners may authorize another individual to act for, and as a representative of the owner. This is the "Authorized Agent." The facility owner is responsible for compliance with program rules and requirements, penalties and repayment of any overpayments.

Authorized Agent Name, if different than owner (First/Middle/Last): _____

☐ I authorize signatory authority to the following individual(s):

First and Last Name of individual:_____ Title:_____

First and Last Name of individual:_____ Title:_____

First and Last Name of individual:_____ Title:_____

☐ My signature is the only authorized signature.

CHILDREN RESIDING IN A FACILITY: The Child Care Assistance Program (CCAP) may not be billed for child care services provided for children residing in a United States Department of Defense or United States Coast Guard Certified, Tribally Approved or Certified, or Nationally Accredited or Certified Day Camp or similar child care facility. Children under13 years of age, residing in a facility are included in the facility's capacity regardless of CCAP participation.

OPERATING HOURS: Operating hours must be less than 24 hours in a day. Care can only be authorized to you during your operating hours. If you do not regularly provide care on a specific day of the week you may either write "closed" or leave the box blank. If left blank it will be determined care is regularly not provided that day and care provided will not be authorized or paid. List the beginning and ending times of day, including a.m. and p.m.

Monday: _____ am / pm to _____ am / pm **Tuesday**: _____ am / pm to _____ am / pm

Wednesday: _____ am / pm to _____ am / pm **Thursday**: _____ am / pm to _____ am / pm

Friday: _____ am / pm to _____ am / pm **Saturday**: _____ am / pm to _____ am / pm

Sunday: _____ am / pm to _____ am / pm

SCHEDULED CLOSURES (SUCH AS HOLIDAYS): List the days and/or dates you will be closed and not providing child care services on an annual basis:_____
_____

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. 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.

FRAUD PENALTY WARNINGS: You may be prosecuted or otherwise sanctioned if you knowingly give false, incorrect or incomplete information to obtain or try to obtain Child Care Assistance Program payments you are not eligible for, or to help someone else obtain payments for 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 disqualified from program participation and obligated to repay any amounts attributable to the intentional program violation or fraudulent act(s), in addition to any applicable criminal penalties.

CERTIFICATION AND STATEMENT OF TRUTH: This section, in addition to the Alaska child care assistance statutes and regulations, should be carefully read and understood prior to signing the application.

I have accessed a copy of the Alaska Child Care Assistance Program Statutes and Regulations: AS 47.05, AS 47.25.001- 47.25.095, and 7 AAC 41, and have read, understand and agree to comply with them.

I will cooperate with the Department of Health (DOH) including inspection and investigation and permit representatives of the DOH to have full access to inspect and investigate the child care facility and premises, review records, interview staff and interview individuals and their families receiving services.

I understand that I am required to maintain and retain records necessary to demonstrate compliance with the Alaska Child Care Assistance Statutes and Regulations. In addition, I will make these records available to the DOH or its authorized representatives, upon request; and

Under penalty of perjury or unsworn falsification, I certify that the statements made on this application are true and correct; and that I have read, or had read to me, and understand the information provided on this application.

I understand that I am responsible for compliance with program rules and requirements, penalties and repayment of any overpayments. I further understand I will not receive any payment for child care services provided prior to the determination of my eligibility and issuance of approval regarding my child care assistance application as a United States Department of Defense or United States Coast Guard Certified, Tribally Approved or Certified, or Nationally Accredited or Certified Day Camp or similar child care facility.

_____

Printed Name of Owner

_____ _____

Signature of Owner Date

_____

Printed Name of Provider's Authorized Agent (if applicable)

_____ _____

Signature of Provider's Authorized Agent (if applicable) Date