



CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

Office Use Only

MANUAL AUTHORIZATION REQUEST FORM - PASS I

Submit the completed form to the child care assistance office serving the family's region. A separate form is required for each month of care needed.

Reason for Manual Authorization Request, select one:

- Child excluded due to being a SSI recipient
Child lives with a family on ATAP, but is not part of the ATAP Family unit (loco parentis)
Child lives with a family on ATAP but the Primary Individual of the ATAP family unit is not a qualified alien
Request to cancel current authorization for the service month of:
due to higher level of care needed. Submitting new request with this request
Other, please explain:

Beginning Date of Care: (MM/DD/YY) End Date of Care: (MM/DD/YY)

Parent Information:

Name (Last, First)
Client ID Number Phone Number
Physical Address (if homeless please indicate above)
Mailing Address

Child Care Provider Information - A separate form must be completed for each child care provider.

Primary or Secondary
Provider/Facility Name
Provider/Facility ICCIS ID Number, if known Phone Number
Physical Address
Mailing Address

Note: If there are more than 4 children, use additional Manual Authorization Request Form – PASS I’s and submit them together.

Name of Child (Last, First)

Birthdate (MM/DD/YY)

Part Month Full Month or Additional Days of Care Needed: PT _____ or FT: _____
Alaska IN! Supplement Percentage: _____

Name of Child (Last, First)

Birthdate (MM/DD/YY)

Part Month Full Month or Additional Days of Care Needed: PT _____ or FT: _____
Alaska IN! Supplement Percentage: _____

Name of Child (Last, First)

Birthdate (MM/DD/YY)

Part Month Full Month or Additional Days of Care Needed: PT _____ or FT: _____
Alaska IN! Supplement Percentage: _____

Name of Child (Last, First)

Birthdate (MM/DD/YY)

Part Month Full Month or Additional Days of Care Needed: PT _____ or FT: _____
Alaska IN! Supplement Percentage: _____

Provide justification to support the units of care included in this request:

Case Manager Printed Name

Agency Name

Direct Phone Number

Date

Supervisor Printed Name

Supervisor Signature

Direct Phone Number

Date