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