CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

Office Use Only

CHILD CARE ASSISTANCE PROGRAM PROVIDER REPORT OF CHANGE

Printed Provider First and Last Name:_____

Facility Name, if any:_____ ICCIS Number:_____

LICENSED PROVIDERS ONLY

CHANGE OF ADMINISTATOR: Informational only. Change of Administrator must be reported to child care licensing and the individual approved as the Administrator.
First and Last Name of Administator:_____

CHANGE OF SIGNATORY AUTHORITY: Newly named individuals must complete the Child Care Assistance Provider Billing Training prior to submission of *Request for Payment* forms signed by that individual. As the facility owner, President or Registered Agent, or Administrator:

☐ My signature is the only authorized signature. (Owner; President or Registered Agent, if a corporation; or Administrator Only). If a new Administrator is completing this form, they must be approved as the facility's Administrator by licensing in order for these changes to be acceptable.

☐ I authorize signatory authority for the Child Care Assistance Program to the following individual(s):

First and Last Name of Individual: _____ Title:_____

First and Last Name of Individual: _____ Title:_____

☐ Signatory authority is no longer authorized to the following individual(s):

First and Last Name of individual:_____Title:_____

First and Last Name of individual:_____Title:_____

APPROVED RELATIVE AND IN-HOME PROVIDERS ONLY

CHANGE OF ADDRESS / CONTACT INFORMATION: A 30 calendar day notice must be given prior to a change of mailing or physical address to the Child Care Assistance Program. Additional paperwork is required as noted below.

☐ **MAILING ADDRESS CHANGE:** Attach a completed *State of Alaska Substitute Form W9*.
Effective Date of Change:_____ New Mailing Address: _____

☐ **PHYSICAL ADDRESS CHANGE:** Your current approval does not transfer to a new physical location. You must submit a completed Child Care Provider Application applicable to your provider type and a *Get Out Alive! Disaster Preparedness and Emergency Evacuation Plan* CC10 form reflecting the new physical address. If you are an Approved Relative provider renting at the new location, you will also need to submit a completed *Permission to Operate A Child Care Business* CC72.

Effective Date of Change:_____ New Physical Address: _____

APPROVED RELATIVE AND IN-HOME PROVIDERS ONLY

☐ **CONTACT PHONE NUMBER CHANGE**

Home phone number:_____ Cell phone number:_____

Email Address:_____ Fax Number: _____

☐ **NAME CHANGE:** Attach a copy of the government issued photo identification supporting the name change. Approved Relative providers must also submit a completed *State of Alaska Substitute Form W9.*

Print Provider's New First, Middle, Last Name: _____

APPROVED RELATIVE AND IN-HOME PROVIDERS ONLY

CHANGE IN HOURS OF OPERATION/SCHEDULED CLOSURES

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 changes in the days and/or dates you will be closed and not providing child care services on an annual basis:_____

_____

APPROVED RELATIVE PROVIDERS ONLY

CHANGE OF INDIVIDUALS LIVING IN THE CHILD CARE HOME: A valid background check is required for all individuals 16 years of age and older moving into the child care home. Print the information below for individuals moving into or out of the child care location. If individuals 16 years of age and older are moving out of the child care you must terminate their association with your provider case in the New Alaska Background Check System. If more changes in your household are being reported, please use an additional sheet of paper.

☐Moved In Date:_____ or ☐ Moved Out Date:_____

_____	_____	_____	_____
First, Middle, Last Name	Birth Date	Age	Relationship to Provider

☐Moved In Date:_____ or ☐ Moved Out Date:_____

_____	_____	_____	_____
First, Middle, Last Name	Birth Date	Age	Relationship to Provider

APPROVED RELATIVE PROVIDERS ONLY

CHANGE OF CHILDREN IN CARE: Print the information for the children who are no longer in your care and the date care ended. Also print the information for new children to be in your care and when care will begin and attach verification of the qualifying relationship. If more changes in the child(ren) in your care or who will be in your care are being reported, please use an additional sheet of paper.

1. ☐ Care Begins Date:_____ or ☐Care End(ed) Date: _____

_____	_____	_____	_____
First, Middle, Last Name	Birth Date	Age	Relationship to Provider

2. ☐Care Begins Date: _____ or ☐Care End(ed) Date: _____

_____	_____	_____	_____
First, Middle, Last Name	Birth Date	Age	Relationship to Provider

3. ☐Care Begins Date: _____ or ☐Care End(ed) Date: _____

_____	_____	_____	_____
First, Middle, Last Name	Birth Date	Age	Relationship to Provider

IN-HOME CHILD CARE PROVIDERS ONLY

CHANGE OF IN-HOME CAREGIVER

Current Caregiver Name:_____ Last date providing care:_____

You must terminate this individual from your New Alaska Background Check System provider case. Attach a completed *In-Home Child Care Application* packet with all the required documentation. This individual must have a valid background check through the Alaska Background Check Program prior to care beginning.

Provider Signature:_____ Date:_____