CHILD CARE ASSISTANCE PROGRAM
ALASKA INCLUSIVE CHILD CARE PROGRAM

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

Office Use Only

REQUEST FOR HEARING

If you as a family disagree with a determination to: deny your application for program participation, or reduce, suspend, or terminate your benefit as a participating family made by the Child Care Program Office or local child care assistance office, you may request a hearing under 7 AAC 49.

If you as a child care provider disagree with a determination to: deny, suspend, or terminate your ability to participate in the program; or disagree with the amount of payment received for services provided under the program, you may request a hearing under 7 AAC. 41.443.

All requests for a hearing must be made in writing within 30 days of the date of the notice in which you are in disagreement. A written request for a hearing may be mailed to or submitted to the Child Care Program Office at the address above. A hearing is not a trial. It will be conducted in an informal manner and will be attended by a representative of the Department and by you and or your representative, if applicable. If you need assistance requesting an administrative hearing, please contact the Child Care Program Office, in person or by phone at (907) 269-4500.

Select only one: I am a: ☐ Family OR ☐ Child Care Provider

Please Print

First, Middle, and Last Name:_____

Mailing Address:_____

Telephone Number:_____ ICCIS ID Number (if known):_____

Signature of Requestor:_____

Reason for Hearing Request (attach additional paper if needed):

_____

_____

_____

Families Only – Must select one of the following options

Hearing Requests under 7 AAC.49

☐ Continue my benefits at the level received before this notice until the hearing decision is made. I understand that if the hearing decision is not in my favor, I am responsible for paying back any benefits I receive while waiting for the hearing decision. **FAILURE TO CHECK EITHER BOX WILL RESULT IN BENEFITS CONTINUING.**

☐ Do not continue my benefits at the level received before this notice. I accept the amount stated in this notice, knowing that if the decision is in my favor, benefits will be retroactively issued to the effective date of the incorrect denial, suspension, termination or reduction.