CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office
3601 C Street, Suite 140
PO Box 241809, Anchorage, AK 99524-1809

Office Use Only

SUBSTITUTE CAREGIVER VERIFICATION

Substitute Caregiver Information. Please attach a copy of your government issued photo identification:

Print First, Middle, Last Name: _____
Alias: _____ Date of Birth: _____ SSN: _____

Mailing Address: _____ City: _____ Zip: _____

Physical Address: _____ City: _____ Zip: _____

E-mail Address: _____

Substitute caregiver's relationship (degree of kinship) to children in care, if any: _____

Initial the line at the beginning of each statement to indicate you have carefully read each statement below.

_____ I have read, understand, and am capable of fulfilling the responsibilities and requirements of 7 AAC 41.200 - 7 AAC 41.255;

_____ I understand I must complete the applicable process to have a valid criminal history check before I can be considered eligible;

_____ I cannot provide child care services until I have received approval from the Child Care Assistance Program;

_____ All child care services provided will be conducted at the Provider's approved location;

_____ Any pay or other compensation for child care services will be made to me by the listed provider, and not families using care;

_____ I cannot submit billing reports to the State of Alaska for payment of my services; and

_____ I cannot provide child care services for more than 30 days in any 12-month period.

Provider Information: Provider Type: □ Approved Non-Relative □ Approved Relative

Name of Provider: _____

Provider's Physical Address: _____ City: _____ Zip: _____

Provider's Phone Number: _____

Certification and Statement of Truth

Under penalty of perjury or unsworn falsification, I certify that the above named substitute caregiver has read, understands, and is capable of fulfilling these responsibilities in my absence. I will ensure the substitute caregiver does not provide care for more than thirty (30) days in any twelve (12) month period. The statements made on this document regarding myself and the substitute caregiver are true and correct.

_____ _____

Provider Signature Date