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

TERMINATION OF CHILD CARE SERVICES

Family First and Last Name: _____ ICCIS Case Number, if known:_____

Provider Name: _____ ICCIS Case Number, if known: _____

☐ This serves as the required 14 day written notice that child care services will end. The last date of service will be: _____.
(MMDDYY)

Family is in good standing with payment of all charges/fees or with a payment plan for monies owed to the provider: ☐ Yes ☐ No ☐ Waived – collection of any monies owed by this family is hereby waived.

OR

☐ The required 14 day written notice is hereby mutually waived. The last date of service will be: _____.
(MMDDYY)

Family is in good standing with payment of all charges/fees or with a payment plan for monies owed to the provider: ☐ Yes ☐ No ☐ Waived – collection of any monies owed by this family is hereby waived.

Both the family's responsible party and provider must sign the form when mutually waiving the required notice.

Printed Name of PROVIDER	Signature of Provider Date
Printed Name of FAMILY's Responsible Party	Signature of Family's Responsible Party Date

It is the responsibility of the party ending the services to notify the child care assistance office, within ten (10) business days, at: