CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office
http://dhss.alaska.gov/dpa/Pages/ccare

Office Use Only

FAMILY REPORT OF CHANGE

Printed Family's Parent First and Last Name	ICCIS Case Number, if known

To continue Child Care Assistance Program participation without penalty, you must report the following changes in your circumstance within the timeframes prescribed.

CHANGE IN ELIGIBLE ACTIVITY: Within 10 business days of a non-temporary loss of employment, or ending attendance at a job training or educational program, you must report the change. Your child care benefit will continue for the following 3 months and you will be considered to be participating in job search activities. You must obtain employment or begin attendance at a job training or educational program, report it to this office, and provide verification before the end of this 3 month period, in order to continue program participation.

☐ **EMPLOYMENT** **Parent First and Last Name**:

☐ Employment Ended Employer Business Name: Last Day Worked:
Submit verification including the name of the employer, the last day employed, the date of your last pay check and the gross wages on your last pay check.

☐ **Employment Beginning/Began – verification of activity, wages, and earnings must be provided.** The *Employment Statement* CC36 may be used as verification.
Employment Start Date: Employer Business Name:

Employer Contact Name and Number:

Schedule of work days and times: Mon Tue Wed Thurs Fri Sat Sun

Hourly rate of pay: $ How often/when paid:
Note: Semi-monthly and bi-weekly pay frequencies are different.

☐ **JOB TRAINING / EDUCATIONAL PROGRAM ATTENDANCE** **Parent First and Last Name:**

☐ Attendance Ended Program Name: Last Day Attended:

☐ **Attendance Beginning/Began – verification of program enrollment, class schedule, cost of tuition and fees, and any financial aid received or to be received must be provided**

Program Name: Program Start Date:

CHANGE IN INCOME: Within 10 business days of receiving an increase in either or both earned and/or unearned income, you must report the change if it causes your family's countable monthly income to exceed 85% of the State Median Income. See the *Family Income and Contribution Schedule* to determine if your countable monthly income exceeds 85% of the State Median Income for your family size.

☐ **Increase causing family countable income to exceed 85% of the State Median Income. Attach verification.**	☐ **Decrease not due to employment change above. Attach verification.**
Family Member Name:	Family Member Name:
Name/type of income source changing:	Name/type of income source changing:
Date received: Amount received:	Date received: Amount received:
New amount to continue: ☐Yes ☐ No	New amount to continue: ☐Yes ☐ No

CHANGE IN CHILD CARE NEED: Within 10 business days you must report when an increase of child care coverage is needed due to a change in your eligible activity. If this change is not reported timely, child care will not be covered prior to the change being reported and payment to the child care provider will be the responsibility of the parent.

☐ **Change in days/hours** Child Care Provider Name:

Child(ren) Name(s):

Days/Times care needed: Mon Tue Wed Thurs Fri Sat Sun

CHANGE OF CHILD CARE PROVIDER: At least 10 business days prior to ending care with your child care provider you must give your child care provider written notice. You must also report the change and provide a copy of the written notice given to your child care provider to the child care assistance office within 10 business days of the change occurring.

☐ **Current Child Care Provider Name:**

Date 10 day written notice was given to this child care provider: Last date of care:

Child(ren) Name(s):

☐ **New Child Care Provider Name:**

Date care to begin or began: Child(ren) Name(s):

Days/Times care needed: Mon Tue Wed Thurs Fri Sat Sun

Is full time care needed for school aged children for in-service or school closures: ☐Yes ☐ No

If yes, indicate the names of the children and dates full time care is needed:

☐ **Secondary Provider Needed** Child Care Provider name:

Date Care to begin: Child(ren) Name(s):

Days/Times care needed: Mon Tue Wed Thurs Fri Sat Sun

Is full time care needed for school aged children for in-service or school closures: ☐Yes ☐ No

If yes, indicate the names of the children and dates full time care is needed:

CHANGE IN FAMILY ADDRESS / CONTACT INFORMATION: To ensure we have the most current information in order to contact you please report these changes.

☐ **MAILING ADDRESS CHANGE**

New mailing address:

☐ **PHYSICAL ADDRESS CHANGE**

New physical address:

☐ **CONTACT PHONE NUMBER CHANGE**

Home phone number: Work phone number:

Cell phone number: Other contact number:

Comments:

Family's Parent Signature:_____ Date:_____