



CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

Office Use Only

APPROVED RELATIVE AND IN-HOME CHILD CARE PROVIDER REPORT OF CHANGE

Printed Provider First and Last Name: \_\_\_\_\_

Facility Name, if any: \_\_\_\_\_ ICCIS Number: \_\_\_\_\_

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: \_\_\_\_\_

[ ] 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: \_\_\_\_\_

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.

1.  Moved In Date: \_\_\_\_\_ or  Moved Out Date: \_\_\_\_\_

\_\_\_\_\_  
First, Middle, Last Name                      Birth Date              Age              Relationship to Provider

2.  Moved In Date: \_\_\_\_\_ or  Moved Out Date: \_\_\_\_\_

\_\_\_\_\_  
First, Middle, Last Name                      Birth Date              Age              Relationship to Provider

**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.

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

4.  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: \_\_\_\_\_