Alaska Child Care Resource and Referral Network- Alaska IN!

APPLICATION FOR SPECIAL NEEDS SUPPLEMENT

□ Family Information

Parent/Guardian Name: _____

I am requesting a Special Needs Supplement for:

Child's Name: _____ Date of Birth: _____

Relationship to Child: _____

Physical Address: _____

Mailing Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-Mail Address: _____

□ Provider Information or □ Seeking Child Care Provider

Name of Child Care Provider: _____

Provider Address: _____

Provider Phone: _____

Please read and initial the following requirements.

_____ I understand that I must be receiving State of Alaska child care assistance funds in order for my child's provider to receive the Special Needs Supplement.

_____ I am participating in the following state Child Care Assistance Program:

_____ **PASS I** - Division of Public Assistance (DPA)
DPA office community/contact: _____

_____ **PASS II or PASS III** - Local Administrator (LA)
LA office community/contact: _____

_____ I understand that Alaska IN! is a project supported by the State of Alaska and files my be reviewed for auditing purposes only.

_____ _____
Parent/Guardian Signature Date

For Office Use Only	**Date Received**
• Documentation of Special Need	_____
• Authorization for Exchange of Information	_____
• Accommodations Scale	_____
• Scoring Sheet for Accommodations Scale	_____
• Provider Training Plan	_____
• Special Needs Supplement Authorization	_____

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