NON CHILD CARE ASSISTANCE PROGRAM CHILDREN'S ATTENDANCE

Care provided during the month and year of: _____

ICCIS # _____
(If you do not have an ICCIS #, leave blank)

Facility Provider Name: _____
Phone Number: _____

VCN # _____
(If you do not have a VCN #, leave blank)

FOR CCPO USE ONLY

Last, First (Child)	**Last, First (Parent)**	**AGE (I, T, P, S)**	**Full Days**	**Part Days**	**Full Days + Part Days**	**FT MO +**	**PT MO+**	**Total**

FOR CCPO USE ONLY
Totals
This page $_____
All pages $ _____
Date Verified:_____
Verifier Initials:_____

STATEMENT OF TRUTH: Under penalty of perjury or unsworn falsification, I certify that the information provided on this form for the period indicated are true and accurate. I understand that if I provide false information on or with this form it may result in a determination of an intentional program violation and, any money obtained as a result must be paid back to the State of Alaska and a penalty will be imposed up to and including disqualification from program participation.

_____ _____ _____
Printed Name of Individual Signature of Individual Date