Attachment B

Massachusetts Department of Transitional Assistance
Child Care Referral Notice

Name _____ SSN _____

Address _____ TAO _____

City/Town, ZIP _____ Date _____

Dear

This is a referral for you to take to the Child Care Resource and Referral Agency (CCR&R) listed below to obtain a voucher for child care services. A child care voucher cannot be backdated.

A child care provider will not receive payment until a voucher has been issued by the CCR&R.

You must report changes in your income or component activity to your AU Manager within 10 days of the change.

If your TAFDC case is closed and you receive Transitional Child Care benefits, you must report changes in your income to the CCR&R counselor within 10 days of the change.

CCR&R Name and Address: _____

_____

RECIPIENT INFORMATION

Program:
Telephone Number:
Date of Birth:
Primary Language:
Ethnic Origin:

Current Monthly Grant:
Other Income Received:
TAFDC Case Closing Date:
Child Care Service Reason:

Enter the activity(ies), the start and end dates of the activity(ies), and the start and end times per day for each activity.

Component Activity	Start Date	End Date	Sun.	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.
Total Hours*									

* Total Hours shown above do not include the recipient's travel time to and from the activity when van services are not provided by the child care vendor, therefore, additional hours must be added to the Total Hours.

The Total Hours may, on rare occasions, fluctuate based on an unanticipated change in the component activity. Accommodations should be made to the extent possible.

(see reverse side)

BEA/CCA (Rev. 4/2005)
25-105-0405-05

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If you have any questions or you disagree with the information on this child care referral, call your worker at the phone number listed below. If you disagree with the referral, you have the right to request a hearing before a Department of Transitional Assistance hearing officer. If you disagree with the action or inaction taken by the CCR&R or the child care provider, you have the right to request a hearing before an Office of Child Care Services hearing officer.

Child(ren) Name(s) Child(ren) Date(s) of Birth

_____ _____ _____ _____

Signature of Recipient Date Signature of AU Manager Date

_____

TAO Address

_____

Telephone Number

_____

TAO Fax Number

Response from CCR&R to DTA upon final disposition of this referral:

❑ All CC Referrals Refused by Recipient ❑ CC Not Available

_____ _____

Signature of CCR&R Counselor Date