

**Massachusetts Department of Transitional Assistance
Child Care Referral**



Notice Information			
Parent/Caregiver 1		APID	
Parent/Caregiver 2		APID	
Address		Local Office (TAO)	
City/Town, Zip		Date	

To get child care you must contact the Child Care Resource and Referral Agency (CCR&R) listed below to obtain a voucher for child care services. Please be advised that your child care provider **will not** receive payment for child care that began prior to the CCR&R issuing your voucher.

CCR&R Name _____
 Address _____
 Phone Number _____

Personal Information of Parent/Caregiver 1			
Program	TAFDC	Date of Birth	
Telephone Number		Primary Language	

Activity Information	
Activity Type	Child Care Need
<input type="checkbox"/> Seeking Activity/Employment Planning <input type="checkbox"/> Approved ESP Activity <input type="checkbox"/> Transitional Child Care TAFDC Case Closing Date	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

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

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 information on this referral, you have the right to request a hearing before a Department of Transitional Assistance hearing officer. If you disagree with the actions taken by the CCR&R or the child care provider, you have the right to request a hearing before a hearing officer from the Department of Early Education and Care.

Case Manager Name and Information	
Assistance Unit Manager Name	
Telephone Number	
Fax Number	617-887-8765

Massachusetts Department of Transitional Assistance
Child Care Referral



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

*** This is page 2 - use as needed ***