

**Child-Care Authorization
Massachusetts Department of Transitional Assistance**

Date _____

NAME _____ SSN _____

ADDRESS _____

CITY/TOWN, ZIP _____

TAO _____ TAO Phone Number _____

Dear _____

This is an Authorization 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 may not 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 and CCR&R counselor within five days.

CCR&R Name and Address: _____

RECIPIENT INFORMATION

Program:	Current Monthly Grant:
Telephone Number:	Other Income Received:
Date of Birth:	TAFDC Case Closing Date:
Primary Language:	Child-Care Service Reason:
Ethnic Origin:	

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

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

Total number of hours does not include needed transportation time.

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

Signature of Recipient Date Signature of AU Manager Date