STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814

February 17, 1993

ALL-COUNTY LETTER NO. 93-12

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY TCC COORDINATORS

Reason for this Transmittal	
[ ]	State Law Change
[ ]	Federal Law Change
[ ]	Court Order or Settlement Agreement
[X]	Clarification Requested by One or More Counties
[ ]	Initiated by CDSS

SUBJECT: CLARIFICATION OF TIME LIMITS FOR TRANSITIONAL CHILD CARE (TCC) PROGRAM

The purpose of this letter is to clarify the time limits for eligibility and payment processing in the TCC Program. Administrative Adjudications and federal staff who have conducted county reviews on the TCC Program have informed us that they have found inconsistent policies in this area. The three areas of concern are the beginning date of the TCC eligibility period, TCC application processing, and the processing of requests for TCC payments. Please review your current policies and procedures to ensure compliance with TCC regulations as explained below.

Beginning Date of the TCC Eligibility Period

Some counties have been using incorrect dates to begin the TCC eligibility period. Usually this has occurred when counties use the computer system termination date which may not be the same as the first actual date of Aid to Families with Dependent Children (AFDC) ineligibility. According to the Manual of Policies and Procedures (MPP) Section 47-125.1, TCC eligibility begins on the first day of the first month in which a family is ineligible to receive AFDC. Therefore, counties should be evaluating every AFDC case record to use the earliest date of AFDC ineligibility in determining the appropriate TCC eligibility period.

TCC Application Processing

Some counties have been denying TCC applications because they were not submitted immediately upon the family's discontinuance from AFDC. As noted in MPP Section 47-105.12, the family can submit an application for TCC benefits any time during the twelve month eligibility period. As long as the remaining eligibility requirements are met, retroactive TCC benefits can be paid according to MPP Section 47-125.2.

Processing of the Request for TCC Payments

Some counties have been denying payment requests for months that are within the TCC eligibility period because they are being submitted by the family after the TCC termination date. According to MPP Section 47-165.62, the family can submit completed Requests for TCC Payments any time during the twelve month eligibility period plus an additional month after the eligibility period has expired. This additional month allows time for the family to submit any remaining Requests for TCC Payments that are for child care provided during the twelve month TCC eligibility period.

Additionally, in order to inform the TCC recipient of their responsibilities concerning these time limits, we have revised the following forms and Notice of Action (NOA) messages:

- NOA Message No. M47-120A/Client Ineligible for TCC
- NOA Message No. M47-125/Client is Eligible for TCC
- TCC 1 Coversheet/Request for Transitional Child Care (TCC) Benefits - Coversheet
- TCC 1 Long Form/Request for Transitional Child Care (TCC) Benefits
- TCC 1A Coversheet/Request for Transitional Child Care (TCC) Benefits - Coversheet
- TCC 1A Short Form/Request for Transitional Child Care (TCC) Benefits
- TCC 43/Request for Transitional Child Care (TCC) Payment

For your reference, we have enclosed copies of the revised forms and NOA messages. To obtain camera-ready copies of the revised forms, telephone or write to:

CDSS Forms Management Unit
744 P Street, MS 7-182
Sacramento, CA 95814

(916) 657-1907 or ATSS 437-1907

These forms will be translated into the five standard languages and sent to counties under separate cover as soon as they are available.

If you have any questions, please call Ms. Jan DeSilva of the Child Care Programs Section at (916) 654-1768.

MICHAEL C. GENEST
Deputy Director
Welfare Programs Division

Enclosures

State of California
Department of Social Services

Manual Msg. No.: M47-120A
Action : Disc.
Reason: TCC Ineligible
Title: Client Ineligible For TCC

Auto ID No. :
Flow Chart No.:
Source :TCC
Regulation Cite: See Below

Form No. :NA290
Effective Date :04/01/90
Revision Date :01/01/93

MESSAGE: As of _____, the County is stopping your Transitional Child Care (TCC) money.

Here's why:

[ ] You can get TCC for only twelve months. Your twelve months are up. (Reg. Cite 47-125.1)

[ ] To get TCC, you must have a child in the home who is under the age of 13, or can't care for him/herself, or is under court supervision. You don't have any TCC eligible children in the home. (Reg. Cite 47-120.1)

[ ] You are on cash aid. You can't get TCC while on cash aid. If you go off cash aid, you may get TCC again. Contact your worker. (Reg. Cite 47-120.1)

[ ] You quit your job without good reason. (Reg. Cite 47-170.1)

[ ] To keep getting TCC, you must give the County a signed and completed TCC Status Report. You didn't do this. If you turn in the report, the county will review your case and notify you. (Reg. Cite 47-175.2)

[ ] You don't need child care since another adult in your family can provide child care. (Reg. Cite 47-120.1)

[ ] You didn't help meet the Child Support rules. (Reg. Cite 47-170.2)

You have one month after the County stops your TCC to turn in all your Requests for TCC Payments.

INSTRUCTIONS: Use to discontinue TCC when the recipient becomes ineligible.

Fill in the date and the appropriate reason for discontinuance. For the Child Support box, indicate what action was necessary.

State of California
Department of Social Services

Manual MSG. No.: M47-125
Action : Approve
Reason: TCC Eligible
Title: Client is Eligible For TCC

Auto ID No. :
Flow Chart No.:
Source : TCC
Form No. : NA290
Effective Date : 04/01/90
Revision Date : 01/01/93
Regulation Cite: 47-125.1, 47-130.1, 47-155.1, .4, .7

MESSAGE: As of _____, the County has approved your application for Transitional Child Care (TCC). You may get TCC for the twelve month period ending _____.

Each month you must pay a fixed part of your child care costs. This is called a family fee. Based on your income of $_____ as shown below and family size of _____, your family fee is $_____.

_____	$_____
_____	_____
_____	_____
Total Income:	$_____

You must pay your family fee each month to your child care provider.

Your family fee may be refigured. If something changes, you can ask at anytime for your family fee to be refigured.

The County will help pay part of your child care costs each month. There will be a limit on this amount based on the child's age, child care provider and hours of child care.

You must turn in a Request For TCC Payment for each month that you want TCC money. You have one month after the County stops your TCC to turn in your last Requests for TCC Payments.

INSTRUCTIONS: Use to approve TCC where payments will be made directly to the client.

Fill in the date of approval and the end of the 12 month eligibility period. Fill in the family fee, income and family size. Identify each person with income and their gross income amount.

REQUEST FOR TRANSITIONAL CHILD CARE (TCC) BENEFITS – COVERSHEET

WHAT IS TCC?

- TCC may help you pay part of your child care after you go off Federal Aid to Families with Dependent Children (AFDC).
- You may get TCC for up to 12 months in a row beginning with the first month you become ineligible for AFDC.
- You must pay part of the cost for your child care which is called the Family Fee. It is based on the gross earnings of TCC family members and the number of members in the family.
- IMPORTANT: The TCC family must pay the Family Fee and any child care costs above the TCC benefit.
- You must have received AFDC three out of the last six months before you were ineligible for AFDC; and, AFDC must have stopped due to:
  - Increased earnings;
  - Loss of the $30 and 1/3 income disregard; or
  - Increased hours of work.
- You must work and pay child care costs for a child under age 13 years; or, for an incapacitated child or child under court supervision who needs care.
- A child in your home who gets SSI or Foster care can get TCC.
- Your Family Fee will be refigured once after you get 6 months of TCC, unless you ask your worker to figure it again at another time.
- TCC can't be paid when the provider is under 18 years old or to a parent, legal guardian or member of the TCC family.

YOUR RIGHTS:

- To ask for TCC verbally; but a written request must be completed before payment can be made.
- To be told about your Rights and Responsibilities.
- To apply for TCC any month during the 12-months after you are ineligible for AFDC. You may apply by mail, but the County may ask you to come in.
- To be told in writing when your application is approved or denied or your benefits change or stop.
- To choose the child care provider that is best for you and your child(ren). Child care providers must be licensed with the State of California unless they are exempt. Exempt means non-licensed care of your children by a friend, neighbor or relative in your home or their home. The friend or neighbor may only care for your children and theirs without a license. Exempt care is also after-school programs provided by school districts at grammar schools.

YOUR RIGHTS

- To have your Family Fee refigured if your situation changes by asking your TCC worker.
- To have your TCC benefit transferred to another California county if you move and are still eligible. You must tell your worker that you have moved.
- To ask for a state hearing if you disagree with any action taken by the county. If you ask for a hearing within 10 calendar days of your Notice of Action or within 10 calendar days after the TCC payment was made, TCC benefits shall be paid pending the hearing up to the date of settlement, but no longer than the remaining TCC eligibility period.
- To be served without regard to race, color, national origin, religion, political affiliation, marital status, sex, handicap or age. You may file a complaint if you feel you have been discriminated against.

YOUR RESPONSIBILITIES

You Must:

- Pay your Family Fee to your child care provider every month.
- Choose a clean, healthy and safe environment for your child care.
- Give us a completed request for child care payment every month you want a payment.
- Give us your last completed request for child care payment by the last day of the month following the month your TCC stops.
- Give us a completed TCC Status Report when needed.
- Give us the facts that we need and show proof of them as needed.
- Pay back any child care paid to you in error even if the payment was made to the child care provider.

TCC MAY STOP IF:

- You don't cooperate with the District Attorney to help get child support.
- You stop your job without a good reason.
- You don't pay your share of the child care cost.
- You no longer have an eligible child in the home.

PENALTY WARNING

- Failure to report facts or giving wrong or incomplete facts for TCC can result in legal prosecution with penalties of a fine, imprisonment or both.

REQUEST FOR TRANSITIONAL CHILD CARE (TCC) BENEFITS

COUNTY USE ONLY

DATE RECEIVED:

WRITTEN REQUEST:

VERBAL REQUEST:

INSTRUCTIONS: ***If you want TCC, read the coversheet to this application before you fill out the questions below. Please use ink. Attach another sheet of paper if you need more space. You will need to show proof of earnings, hours worked, hours of child care and child care costs.***

Return the completed form to the County Welfare Department (CWD). The CWD will tell you whether you can get TCC and what your family fee will be.

If you need help or have questions, ask the TCC Worker.

APPLICANT'S NAME (FIRST, MIDDLE, LAST)	ADDRESS (STREET, CITY, STATE, ZIP CODE)
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	PHONE ( )

☐ AFDC Received 3 out of last 6 months

Number months on GAIN TCC:

☐ Not Applicable

1. Did you or your family receive aid anywhere within the last 6 months? ☐ YES ☐ NO

If "YES", specify under what name, where, when and type(s) of aid you got.

2. List the children who are living with you and you pay child care for.

(Include children who receive Foster Care or SSI benefits.)

CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
BIRTHPLACE (CITY/STATE)	RELATIONSHIP TO APPLICANT	

CITIZEN/ALIEN STATUS

☐ U.S. Citizen ☐ Legal Alien ☐ Refugee① ☐ Undocumented Alien ☐ Other:

Is this child disabled or under court supervision? ☐ YES ☐ NO

If "YES", explain:

☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was in AFDC/AU
☐ Over 13
☐ Disabled
☐ Court Supervision

CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
BIRTHPLACE (CITY/STATE)	RELATIONSHIP TO APPLICANT	

CITIZEN/ALIEN STATUS

☐ U.S. Citizen ☐ Legal Alien ☐ Refugee① ☐ Undocumented Alien ☐ Other:

Is this child disabled or under court supervision? ☐ YES ☐ NO

If "YES", explain:

☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was in AFDC/AU
☐ Over 13
☐ Disabled
☐ Court Supervision

CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
BIRTHPLACE (CITY/STATE)	RELATIONSHIP TO APPLICANT	

CITIZEN/ALIEN STATUS

☐ U.S. Citizen ☐ Legal Alien ☐ Refugee① ☐ Undocumented Alien ☐ Other:

Is this child disabled or under court supervision? ☐ YES ☐ NO

If "YES", explain:

☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was in AFDC/AU
☐ Over 13
☐ Disabled
☐ Court Supervision

CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
BIRTHPLACE (CITY/STATE)	RELATIONSHIP TO APPLICANT	

CITIZEN/ALIEN STATUS

☐ U.S. Citizen ☐ Legal Alien ☐ Refugee① ☐ Undocumented Alien ☐ Other:

Is this child disabled or under court supervision? ☐ YES ☐ NO

If "YES", explain:

☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was in AFDC/AU
☐ Over 13
☐ Disabled
☐ Court Supervision

3. List all other persons living in your home (include yourself, other children not listed above, parents, stepparents, grandparents, etc.)

NAME (FIRST, MIDDLE, LAST) | DATE OF BIRTH | SOCIAL SECURITY NUMBER ___ ___

BIRTHPLACE | CITIZEN/ALIEN STATUS (✓) ☐ U.S. Citizen ☐ Legal Alien ☐ Refugee ☐ Undocumented Alien

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed | RELATIONSHIP TO CHILD(REN)

NAME (FIRST, MIDDLE, LAST) | DATE OF BIRTH | SOCIAL SECURITY NUMBER ___ ___

BIRTHPLACE | CITIZEN/ALIEN STATUS (✓) ☐ U.S. Citizen ☐ Legal Alien ☐ Refugee ☐ Undocumented Alien

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed | RELATIONSHIP TO CHILD(REN)

NAME (FIRST, MIDDLE, LAST) | DATE OF BIRTH | SOCIAL SECURITY NUMBER ___ ___

BIRTHPLACE | CITIZEN/ALIEN STATUS (✓) ☐ U.S. Citizen ☐ Legal Alien ☐ Refugee ☐ Undocumented Alien

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed | RELATIONSHIP TO CHILD(REN)

4. Did anyone move into or out of your home since AFDC benefits stopped? ☐ YES ☐ NO
(Include newborns or anyone who died.)

NAME:	RELATIONSHIP TO YOU	WHAT HAPPENED	DATE:

5. Complete the information below for anyone who works or expects to work.
- Include all earnings and tips. Attach paystubs or other proof of earnings.
- If self-employed, list business expenses on a separate sheet of paper and attach proof.

NAME:	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS:

HOW OFTEN PAID (WEEKLY, BI-WEEKLY, MONTHLY)	DATE JOB STARTS OR STARTED	DAYS WORKED PER MO.	HRS. WORKED PER MONTH	AMOUNT BEFORE DEDUCTIONS?
				$

NAME:	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS:

HOW OFTEN PAID (WEEKLY, BI-WEEKLY, MONTHLY)	DAYS WORKED PER MONTH	HOURS WORKED PER MONTH	AMOUNT BEFORE DEDUCTIONS?
			$

6. Has anyone had a change in health insurance coverage since AFDC benefits stopped? (Include all health care plan; such as: dental, vision, hospitalization, long-term care insurance; or, health plans such as Kaiser, Ross-Loos, Blue Cross, Champus, etc., whether paid for by you, your employer, or other person). ☐ YES ☐ NO

If "Yes," complete below.

NAME OF INSURANCE COMPANY	WHO IS COVERED	TYPE OF INSURANCE	MONTHLY PAYMENT

COUNTY USE ONLY

☐ Was in AFDC/AU

☐ Was in AFDC/AU

☐ Was in AFDC/AU

Total number of TCC family members:

☐ Was in AFDC/AU

☐ Income and hours verified.

☐ Income and hours verified.

☐ Other insurance coverage:

☐ Medi-Cal card coded for insurance

☐ DHS 6155 to recovery

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification.
- I understand that TCC must be needed to permit a member of the AFDC family to accept or retain employment and that there must not be an adult in the TCC family available to care for the child(ren).
- I understand that I must repay any TCC benefits I am not entitled to receive, even when the benefits are paid directly to the provider.
- I have read (or it was read to me) and received a copy of the TCC Coversheet and I understand my Rights and Responsibilities.
- I understand that failing to report facts or giving wrong or incomplete facts for TCC can result in legal prosecution with penalties of a fine, imprisonment or both.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this application is true and correct.

SIGNATURE OF APPLICANT	DATE SIGNED	PHONE NUMBER WHERE YOU MAY BE REACHED IN CASE YOUR WORKER NEEDS TO CONTACT YOU
		( )

SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON	DATE SIGNED

COUNTY USE ONLY

CASE NAME	CASE NO.

☐ APPROVED ☐ DENIED	TCC BEGINS	TCC ENDS:

REASON FOR DENIAL:

TCC WORKER:	DATE:

SUPERVISOR	DATE:

COMMENTS:

REQUEST FOR TRANSITIONAL CHILD CARE (TCC) BENEFITS – COVERSHEET

WHAT IS TCC?

- TCC may help you pay part of your child care after you go off Federal Aid to Families with Dependent Children (AFDC).
- You may get TCC for up to 12 months in a row beginning with the first month you become ineligible for AFDC.
- You must pay part of the cost for your child care which is called the Family Fee. It is based on the gross earnings of TCC family members and the number of members in the family.
- IMPORTANT: The TCC family must pay the Family Fee and any child care costs above the TCC benefit.
- You must have received AFDC three out of the last six months before you were ineligible for AFDC; and, AFDC must have stopped due to:
  - Increased earnings;
  - Loss of the $30 and 1/3 income disregard; or
  - Increased hours of work.
- You must work and pay child care costs for a child under age 13 years or for an incapacitated child or child under court supervision who needs care.
- A child in your home who gets SSI or Foster care can get TCC.
- Your Family Fee will be refigured once after you get 6 months of TCC, unless you ask your worker to figure it again at another time.
- TCC can't be paid when the provider is under 18 years old or to a parent, legal guardian or member of the TCC family.

YOUR RIGHTS:

- To ask for TCC verbally; but, a written request must be completed before payment can be made.
- To be told about your Rights and Responsibilities.
- To apply for TCC any month during the 12-months after you are ineligible for AFDC. You may apply by mail, but the County may ask you to come in.
- To be told in writing when your application is approved or denied or your benefits change or stop.
- To choose the child care provider that is best for you and your child(ren). Child care providers must be licensed with the State of California unless they are exempt. Exempt means non-licensed care of your children by a friend, neighbor or relative in your home or their home. The friend or neighbor may only care for your children and theirs without a license. Exempt care is also after-school programs provided by school districts at grammar schools.

YOUR RIGHTS

- To have your Family Fee refigured if your situation changes by asking your TCC worker.
- To have your TCC benefit transferred to another California county if you move and are still eligible. You must tell your worker that you have moved.
- To ask for a state hearing if you disagree with any action taken by the county. If you ask for a hearing within 10 calendar days of your Notice of Action or within 10 calendar days after the TCC payment was made, TCC benefits shall be paid pending the hearing up to the date of settlement, but no longer than the remaining TCC eligibility period.
- To be served without regard to race, color, national origin, religion, political affiliation, marital status, sex, handicap or age. You may file a complaint if you feel you have been discriminated against.

YOUR RESPONSIBILITIES

You Must:

- Pay your Family Fee to your child care provider every month.
- Choose a clean, healthy and safe environment for your child care.
- Give us a completed request for child care payment every month you want a payment.
- Give us your last completed request for child care payment by the last day of the month following the month your TCC stops.
- Give us a completed TCC Status Report when needed.
- Give us the facts that we need and show proof of them as needed.
- Pay back any child care paid to you in error even if the payment was made to the child care provider.

TCC MAY STOP IF:

- You don't cooperate with the District Attorney to help get child support.
- You stop your job without a good reason.
- You don't pay your share of the child care cost.
- You no longer have an eligible child in the home.

PENALTY WARNING

- Failure to report facts or giving wrong or incomplete facts for TCC can result in legal prosecution with penalties of a fine, imprisonment or both.

REQUEST FOR TRANSITIONAL CHILD CARE (TCC) BENEFITS

INSTRUCTIONS: *If you want TCC, read the coversheet to this application before you fill out the questions below. Please use ink. Attach another sheet of paper if you need more space. You will need to show proof of any earnings, hours worked, hours of child care and child care costs.*

Return the completed form to the County Welfare Department (CWD). The CWD will tell you whether you can get TCC and what your Family Fee will be.

If you need help or have questions, ask the TCC worker.

COUNTY USE ONLY

Date Received:

Written Request:

Verbal Request:

APPLICANT	SOCIAL SECURITY NUMBER	CASE NAME:
	— —	
ADDRESS	PHONE	CASE NUMBER:
	( )	

1. List the children who are living with you and you pay child care for.

CHILD'S NAME	CHILD'S NAME
A.	C.
B.	D.

2. Did anyone move into or out of your home after AFDC benefits stopped? ☐ YES ☐ NO

(Include anyone who entered or left the home, a newborn, or anyone who died).
If "YES", complete below:

NAME	RELATIONSHIP TO YOU	WHAT HAPPENED	DATE

3. Complete the information below for anyone who works or expects to work.

- Include all earnings and tips. Attach paystubs or other proof of earnings.
- If self-employed, list business expenses on a separate sheet of paper and attach proof.

NAME	EMPLOYER'S NAME AND ADDRESS	DATE JOB STARTS OR WILL START	HOW OFTEN PAID? (WEEKLY, BI-WEEKLY MONTHLY)?	AMOUNT BEFORE DEDUCTIONS?	HOURS OR DAYS WORKED PER WEEK

4. Has anyone had a change in health insurance coverage since AFDC benefits stopped? ☐ YES ☐ NO

(Include all health care plans; such as: dental, vision, hospitalization, long-term care insurance; or health plans such as Kaiser, Ross-Loos, Blue Cross, Champus, etc., whether paid for by you, your employer or other person).
If "YES", complete below:

NAME OF INSURANCE COMPANY	WHO IS COVERED?	TYPE OF INSURANCE	MONTHLY PAYMENT?

☐ AFDC received 3 out of last 6 months.
Number of Months on GAIN TCC:
☐ Not Applicable

A.
☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was In AFDC AU
☐ Over Age 13
☐ Disabled
☐ Court Supervision

B.
☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was In AFDC AU
☐ Over Age 13
☐ Disabled
☐ Court Supervision

C.
☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was In AFDC AU
☐ Over Age 13
☐ Disabled
☐ Court Supervision

D.
☐ Child Under Age 13
☐ Foster Child
☐ SSI
☐ Was In AFDC AU
☐ Over Age 13
☐ Disabled
☐ Court Supervision

☐ Ages Verified
☐ Citizenship/Alien Status Verified
☐ Relationships Verified

Total Number of TCC Family Members:

Total Gross Earned Income: $
☐ Verified

Average Monthly Income: $

☐ Other Insurance Coverage:

☐ Medi-Cal Card Coded for Insurance Coverage

☐ DHS 6155 forwarded to Recovery

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification.
- I understand that TCC must be needed to permit a member of the AFDC family to accept or retain employment and that there must not be an adult in the TCC family available to care for the child(ren).
- I understand that I must repay any TCC benefits I am not entitled to get even when the benefits are paid directly to the provider.
- I have read (or it was read to me) and received a copy of the TCC Coversheet and I understand my Rights and Responsibilities.
- I understand that failing to report facts or giving wrong or incomplete facts for TCC can result in legal prosecution with penalties of a fine, imprisonment or both.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this application is true and correct.

SIGNATURE OF APPLICANT	DATE SIGNED	PHONE NUMBER WHERE YOU MAY BE REACHED IN CASE YOUR WORKER NEEDS TO CONTACT YOU
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON		DATE SIGNED

COUNTY USE ONLY

CASE NAME	CASE NO.

Approved ☐ Denied ☐	TCC BEGINS	TCC ENDS

REASON FOR DENIAL

TCC WORKER	DATE

SUPERVISOR	DATE

COMMENTS:

REQUEST FOR TRANSITIONAL CHILD CARE (TCC) PAYMENT

Instructions: Complete and return this request to your TCC Worker. You will not get a TCC payment unless a request is received each month. Your last request for TCC payment must be received by the last day of the month following the month your TCC stops. Attach proof of hours worked this month. Part A must be completed by you and Part B, on the back of this form, by the Child Care Provider

NEED HELP? ASK YOUR TCC WORKER.

MONTH OF REQUEST:

COUNTY USE ONLY

Date received:

PART A - RECIPIENT FILLS IN THIS SECTION.

NAME (FIRST, MIDDLE, LAST)	HOME PHONE	WORK PHONE
1.	( )	( )

ADDRESS (STREET, CITY, STATE, ZIP CODE)

If your hours of work, child care costs and child care provider have not changed, check the box next to the statement below. Sign your name and list the date on the bottom of this page. If you had changes, complete all of the questions, and sign and date at the bottom.

☐ I declare that my hours of work, child care costs and child care provider have not changed.

2. List each family member who worked.

NAME	TOTAL HOURS WORKED	NAME	TOTAL HOURS WORKED

☐ Total Hours Worked Verified

3. I paid child care costs for this month. ☐ YES ☐ NO

If "YES", complete below.

CHILD'S NAME	PROVIDER'S ADDRESS	AMOUNT PAID

4. Has your child care provider changed since your last request for a TCC payment? ☐ YES ☐ NO

If "YES", complete below.

☐ RMR Changed

PROVIDER'S NAME	PROVIDER'S ADDRESS	PHONE
		( )

Type of Child Care (✓)

☐ Child's Home ☐ Family Day Care ☐ Day Care Center

☐ Before School Care ☐ After School Care ☐ Other (explain):

Type of Provider (✓)

☐ Licensed. List License Number (if Known):

☐ Exempt

Type of Child Care Rate

☐ Family Day Care

☐ Day Care Center

☐ In-Home/Exempt Care

☐ Special Needs Care

CHILD'S NAME	PROVIDER'S RELATIONSHIP TO CHILD:	CHILD'S NAME	PROVIDER'S RELATIONSHIP TO CHILD:

5. Did you pay any application or service fees that are one time only charges? ☐ YES ☐ NO

(Include registration, supply, or cot fees, etc.)

If "YES", complete below.

☐ Fee Verified

Type of Fees	Provider's Name	Amount Charged	Date Paid

CERTIFICATION

- I understand that the child care provider must have a license or not need a license (be exempt) so I can get a TCC payment.
- I understand that the county will pay TCC benefits only for hours of child care reasonably related to the hours I work.
- I understand that I have the right to choose the child care provider who is best for me and my child(ren) and the County may visit the child care site.
- I understand that I must repay any TCC benefits I am not entitled to get.
- I understand that the County does not act as the child care provider's employer; and, does not have a business or contractual relationship with the child care provider when a TCC payment is paid.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this request is true, correct and complete and that the child care was provided.

SIGNATURE OF RECIPIENT	DATE

PART B - CHILD CARE PROVIDER F[illegible] IN THIS SECTION

1. Complete the following informati[illegible] *(Note: If past due fees are owed to you a[illegible] you have not been paid, please comment below).*

Name of Provider	I am at least 18 years of age. ☐ YES ☐ NO

2. Child care is charged: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every Other Week ☐ Monthly ☐ Other (explain):

3. If you charge an hourly, daily or weekly rate for child care, complete below.

a. Child's Name	Week 1	Week 2	Week 3	Week 4	Week 5
	Hours of Care	Hours of Care	Hours of Care	Hours of Care	Hours of Care
	Amount Charged $	Amount Charged $	Amount Charged $	Amount Charged $	Amount Charged $
	Amount Paid $	Amount Paid $	Amount Paid $	Amount Paid $	Amount Paid $
	Date Paid	Date Paid	Date Paid	Date Paid	Date Paid

b. Child's Name	Week 1	Week 2	Week 3	Week 4	Week 5
	Hours of Care	Hours of Care	Hours of Care	Hours of Care	Hours of Care
	Amount Charged $	Amount Charged $	Amount Charged $	Amount Charged $	Amount Charged $
	Amount Paid $	Amount Paid $	Amount Paid $	Amount Paid $	Amount Paid $
	Date Paid	Date Paid	Date Paid	Date Paid	Date Paid

4. If you charge a monthly rate for child care, complete below.

Child's Name	Hours of Care per Week	Amount Charged $	Amount Paid $	Date Paid
Child's Name	Hours of Care per Week	Amount Charged $	Amount Paid $	Date Paid

CERTIFICATION

- I understand that I must have a license or not need a license (be exempt) in order to get a TCC payment.
- I understand that I must provide a clean, healthy and safe place for child care and the County may visit the child care site.
- I understand that I may be required to repay any TCC benefits I am not entitled to get.
- I understand that the County does not act as my employer or have a business or contractual relationship with me when I get a TCC payment.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this request is true, correct and complete and that the child care was provided.

SIGNATURE OF PROVIDER	DATE

Comments: