Child Care Assistance Change Notification Form

Name: ____

Last 4 digits of Social Security Number: ________________________

Spouse Name (if applicable): ______________________________

Contact Number: ______________________________________

E-mail Address: ______________________________________

Change Request: CCA will contact you within 20 business days of the request.
Please fax to 214.688.4436

☐ Mailing Address ☐ Physical Address	Address:__________________________City_____________________ State: _______________ Zip Code:____________
☐ New Contact Number	Home Number:______________________________ Cellular Phone: ______________________________ E: Mail Address: ______________________________
☐ New Martial Status	☐ Married ☐ Single ☐ Separated
☐ Additional Dependants	☐ Birth ☐ Other____
☐ Request - New Child Care Provider	1) Child care authorizations typically begin at the beginning of each month. If your situation is an emergency, please contact our office at 214.630.5949 2) You must go to the requested facility and complete all of their facility documents before child care start. 3) All co-payments must be paid in full before the transfer can be approved. ***Note: Please do not start child care at the new facility until you have heard from CCA. We must authorize child care at the new facility.***
☐ Change of Income	☐ Increase ☐ Decrease ☐ Additional Income Effective Date: ___________ List Additional Income (if applicable): ____________________________
☐ Change in Employment/Training (Includes Job Loss)	**☐ Job Loss** **☐ New Employment/Training** Start Date**:** ____________ Last Day at previous Employer/Training: _____________
☐ Additional Employment	Start Date: ________________
☐ Change in Hours	Start Date: _____________ Days of the Week: ____________________ Work Hours: ______to _________
☐ Temporary Reduction of Co-payment	Reason for the reduction:__________________________________ ____ ***Backup document to verify the need may be required.***