

sheets, etc., showing the date paid, amount paid and check number.
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SUPPORT SERVICE DETERMINATION WORKSHEET
(Please attach to Supportive Service Eligibility Certificate)

Participant Name:		Social Security #:	
Training Component:		Program Operator:	
Transportation			
Mileage (Round Trip) to Training Location (minimum 10 miles required for payment)	x \$.15 per mile	= Daily Payment (not to exceed \$15.00)	
	x \$.15		
Childcare/Dependent Care Costs			
Number of Qualifying Dependents		Daily Payment	
<input type="checkbox"/>	One	\$ _____	(\$12.00 Maximum)
<input type="checkbox"/>	Two	\$ _____	(\$20.00 Maximum)
<input type="checkbox"/>	Three	\$ _____	(\$26.00 Maximum)
<input type="checkbox"/>	Four +	\$ _____	(\$32.00 Maximum)
TOTAL TRANSPORTATION PAYMENT		\$ _____	
TOTAL CHILDCARE/DEPENDENT CARE PAYMENT		\$ _____	
TOTAL DAILY PAYMENT		\$ _____	
EFFECTIVE DATE OF SUPPORT SERVICE PAYMENT			