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Application for

Regional Travel Assistance Grant

Office Use Only – Service ID number Office use only

Regional Travel Assistance Grant (RTAG) payments are made to eligible Family Day Care and In Home Care services in line with the [Community Support Programme Guidelines](http://education.gov.au/community-support-programme-guidelines), as varied from time to time. The current RTAG rate can be found in the CSP Payment Rate Fact Sheet on the department’s website.

# PART A – Service details

| 1. Name of your service:
 |  |
| --- | --- |
| 1. Physical address of the service:
 |  |
|  |
|  |
| 1. Name of Director/Coordinator:
 |  |
| 1. Contact phone number(s):
 |  |
| 1. Is your service Family Day Care or In Home Care:
 |  |

# PART B – Travel details

The following kilometre thresholds apply:

| Kilometre thresholds |
| --- |
| **Size** | **Quarterly kilometre threshold per service** |
| 50 equivalent full time utilised places or less | 975 km |
| 50 – 150 equivalent full time utilised places | 1 950 km |
| More than 150 equivalent full time utilised places | 2 925 km |

| Ground travel |
| --- |
| Vehicle registration: | **Actual kilometres travelled:** | **Number of kilometres over the threshold:** | ***Office use only*****Kms above threshold X rate per km:** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

| Air travel |
| --- |
| From: | **To:** | **Economy fare Paid:** | **Equivalent road kilometres (estimate):** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# PART C – Applicant declaration

* I declare that the information given in this application is complete and correct;
* I authorise the department to verify any information provided in this application; and
* I am authorised to act on behalf of the child care service.

| **Signature of authorised officer:** |  |
| --- | --- |
| **Date:** |  |

| **Name (please print):** |  |
| --- | --- |
| **Position:** |  |

**NOTE**: Giving false or misleading information is a serious offence

# Returning the application

Applications should be submitted to the Department of Social Services office in your State or Territory.

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| I am authorised to sign on behalf of the Department: |  |
| --- | --- |

| Printed name: |  |
| --- | --- |
| Date: |  |