Franklin County
Department of Job & Family Services

Child Care Center
Change Request

Type of Change:	□ Initial	□ Case Termination
	□ Redetermination	☑ Change

Provider E-mail Address:
lsimmons@columbus.k12.oh.us

Case Name: First Middle Last	Case Number:	Requested Start Date of Care:

Street Address:	City:	State:	Zip Code:

Provider Name:	Provider Address:	Provider Vendor Number/ State Id:
Indian Springs Elementary School	50 E. Henderson Ave. Columbus, Ohio 43214	10000 17877

Household Composition	First Name	Last Name	Gender	Social Security Number	Date of Birth Month	Day	Year	Primary (P) or Multiple (M)	Full time(FT)/ Part time (Pt)
Male Adult									
Female Adult									
1st Child									
2nd Child									
3rd Child									
4th Child									
5th Child									
6th Child									
7th Child									
8th Child									

Instructions for change:
Please place the listed children at the above Latchkey Program.

PLEASE READ BEFORE SIGNING: The undersigned child care provider hereby certifies that the information contained herein is true and accurate, and understands that it *(child care provider)* will be held responsible for any overpayment that occurs as a result of having provided inaccurate and/or misleading information. ***(To be signed by provider using ink)***

The undersigned parent/customer hereby acknowledges that a Child Care Center Change Request form must be signed in order to initiate services, to add children, and/or to change a schedule, and that the failure to sign may delay or prevent the processing of the change. By signing this form, I certify that the information contained herein is true and accurate, and understand that I will be held responsible for any overpayment that occurs as a result of having provided inaccurate and/or misleading information.

My signature below also serves as authorization for ***(Provider Name)*** Indian Springs Elementary School to provide FCDJFS with information necessary to determine eligibility for publicly funded child care, and/or to monitor or evaluate the delivery of said care. Any information shared pursuant to this document shall remain confidential according to state and federal law. This authorization shall remain in effect, as needed, unless revoked by me in writing. ***(To be signed by parent/customer using ink)***

Provider Signature	Date
X	
Provider Name **PRINTED**	Telephone Number
Leasa Simmons	(614) 365-5891
Parent/Customer Signature	Date
X	
Parent/Customer Name **PRINTED**	Telephone Number

***** Documentation of Change MUST be submitted with this form *****