

Child Care Center Change Request

Type of Change: ☐ Initial ☐ Case Termination
☐ Redetermination ☒ Change

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

Case Name: First Middle Last			Case Number:			Requested Start Date of Care:			
Street Address:			City:			State:			
Zip Code:			Provider Name: Gables Elementary School			Provider Address: 1680 Becket Ave. Columbus, Ohio 43235			
Provider Vendor Number/ State Id: 10000 18043									
Household Composition	First Name	Last Name	Gender	Social Security Number	Date of Birth			Primary (P) or Multiple (M)	Full time(FT)/ Part time (Pt)
					Month	Day	Year		
Male Adult									
Female Adult									
1 st Child									
2 nd Child									
3 rd Child									
4 th Child									
5 th Child									
6 th Child									
7 th Child									
8 th Child									

Instructions for change:

Please place the listed children at the above school.

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) Gables 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

Shanna Clark

(614) 365-5891

Parent/Customer Signature

Date

X

Parent/Customer Name PRINTED

Telephone Number