

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: Georgian Heights Alternative Elementary School			Provider Address: 784 Georgian Dr. Columbus, Ohio 43228			Provider Vendor Number/ State Id: 10000 19859			
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									
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**) Georgian Heights Alternative 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)*

<u>Provider Signature</u>		<u>Date</u>
X 		
<u>Provider Name PRINTED</u>		<u>Telephone Number</u>
Shanna Clark		(614) 365-5891
<u>Parent/Customer Signature</u>		<u>Date</u>
X		
<u>Parent/Customer Name PRINTED</u>		<u>Telephone Number</u>

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