

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:			
Provider Name: Oakland Park Elementary School			Provider Address: 3392 Atwood Terrace Columbus, Ohio 43224			Provider Vendor Number/ State Id: 10000 17713			
<u>Household Composition</u>	<u>First Name</u>	<u>Last Name</u>	<u>Gender</u>	<u>Social Security Number</u>	<u>Date of Birth</u> Month Day Year			<u>Primary (P) or Multiple (M)</u>	<u>Full time(FT)/ Part time (Pt)</u>
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									

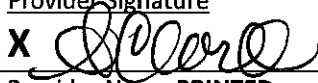
Instructions for change:

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

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