




Child Care Center Change Request

Type of Change:	<input type="checkbox"/> Initial <input type="checkbox"/> Case Termination <input type="checkbox"/> Redetermination <input checked="" type="checkbox"/> Change
Provider E-mail Address:	
lsimmons@columbus.k12.oh.us	

Case Name:	First Middle Last	Case Number:
Street Address:	City:	State:
Provider Name:	Provider Address:	Requested Start Date of Care:
Indianola Informal K-8 Elementary School	251 E. Weber Rd. Columbus, Ohio 43202	10000 18616
	Provider Vendor Number/ State Id:	Zip Code:
	10000 18616	

Household Composition	First Name	Last Name	Gender	Date of Birth			Primary (P) or Multiple (M)	Full time(P)/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 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. <i>(To be signed by provider using ink)</i>									
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) Indianola Informal K-8 Elementary School to provide FCDIFS 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. <i>(To be signed by parent/customer using ink)</i>									
<table style="width: 100%;"> <tr> <td style="width: 60%;"> X  Provider Signature </td> <td style="width: 40%;">Date</td> </tr> <tr> <td> Provider Name PRINTED Leesa Simmons </td> <td>Telephone Number (614) 365-5891</td> </tr> <tr> <td> X Parent/Customer Signature </td> <td>Date</td> </tr> <tr> <td> Parent/Customer Name PRINTED </td> <td>Telephone Number</td> </tr> </table>	X  Provider Signature	Date	Provider Name PRINTED Leesa Simmons	Telephone Number (614) 365-5891	X Parent/Customer Signature	Date	Parent/Customer Name PRINTED	Telephone Number	
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