Home Provider Change Report

Vendor #: _____

To be completed by provider using ink. Completed form to be submitted to the customer's case manager.

Provider's Name: _____ **Address:** _____ **City:** _____ **Zip:** _____ **Phone #:** _____

Parent / Customer's Name: _____ **Case #:** _____, **OR Social Security Number:** _____

Name(s) of Parent/Customer's Children in my care:

_____ _____

_____ _____

_____ _____

Please make the following changes: *(check the appropriate box)*

❑ Place the above stated children in my care. The first day of care is/was: _____

The children's days/hours of care are: _____

_____

As the provider, (check the box that applies), I do ❑ / I do not ❑ provide transportation for this family.
Per rule OAC 5101:2-14-24 (B)(2), I have forwarded a copy of the completed 'Caretaker/Provider Agreement' to the CHID CARE CERTIFICATION UNIT. Without this completed form, my provider file will be considered 'non-compliant' with the aforementioned rule. **I understand that the customer must give documentation of the need for care for these days/hours to their case manager before these days or hours will be considered for payment.**

❑ Terminate the placement from my care. The last day of care was/is: _____

❑ This customer added a child to my care. The name and date of birth for this new child is: _____

_____, and he/she joined my care on *(date)*: _____

❑ The child/children indicated now come different days and/or hours than what is authorized on the 310. Their new schedule began/begins on *(date)*: _____

The new schedule is: _____

_____

The parent/customer must give documentation of these days/hours to their case manager before the schedule can be changed.

PLEASE READ BEFORE SIGNING

Parent/Customer must sign this change form to initiate services, to add child/children, or to change a schedule. Request for termination of service does not require the customer's signature. Forms not containing both the provider's and parent's/customer's signature may result in delayed or failed processing of this change. Also note that by signing the change report you certify that the information indicated is true, and that you understand that for any changes reported, where it is later discovered to be inaccurate or false, may result in an overpayment, and that if an overpayment is discovered to exist, either you as a provider or you as a customer may be held responsible for repayment, and possible other legal actions may be explored.
To be completed by provider using ink.

I, the undersigned hereby authorize you to release and forward to The Franklin County Department of Job and Family Services (agency), upon their request, information contained in your records necessary for the purpose of determining eligibility for Publicly Funded Child Care and/or for the monitoring and evaluating the delivery of publicly Funded Child Care. I have read or have had read and explained to me the above statement, and I fully understand its content. I further understand that any and all information obtained is to be held confidential according to the law.

Provider's Signature: _____ **Date:** _____

Parent's/Customer's Signature: _____ **Date:** _____