CHILD CARE AWARE® of AMERICA FEE ASSISTANCE
PROVIDER CHANGE REQUEST FORM

✸ REASON FOR CHANGE OF PROVIDER (PLEASE SELECT ALL THAT APPLY)

☐ Permanent Change of Station

☐ Change Of Home Address Due To A Recent In State Move

☐ New Provider Closer To Sponsor/Spouse Place Of Employment

☐ New Provider Has Space Available For Each Child In The Family

☐ Unsatisfied With Previous Childcare Provider/Previous Provider Closed Down

☐ New Provider Meets High Quality Accredited Childcare Standards

✸CHILD CARE AWARE® Of AMERICA Fee Assistance Program Requires Notification Fifteen (15) Days Prior To Ending Child Care Services, regardless of who initiates the termination. When care must be terminated sooner, please contact CHILD CARE AWARE® of AMERICA Fee Assistance Program immediately. For assistance in completing this form, please call: 1-800-793-0324.

✸Services Received Prior To The Completion And Approval Of The Change Of Provider Request Will Not Be Reimbursed. Reimbursements will begin once CHILD CARE AWARE® of AMERICA Fee Assistance Program receives and approves all required forms and supporting documents. This includes confirming the new provider qualifications and rates, and finalizing reimbursements to the former provider.

✸If The New Provider Does Not Meet The Eligibility Requirements Of Your Designated Fee Assistance Program (OMCC or MCCYN), Then You (The Sponsor) Are Responsible For Child Care Fees Incurred Until You Secure An Eligible Provider.

✸A Completed Provider Fee Assistance Application must be submitted, along with all the required supporting application documents, for the new provider.

TODAY'S DATE:_____

SPONSOR INFORMATION:

Family Identification Number: _____

Name: _____

Sponsor/Spouse Work Phone Number: _____

Address:_____

City: _____ State:_____ Zip Code: _____

☐ Check If New Address/Phone Number

CHANGE OF PROVIDER APPLIES TO FOLLOWING CHILD(REN):

Child(ren)'s Name:	Date of Birth	Social Security Number:

FORMER PROVIDER INFORMATION**:**

Name: _____

Address: _____

City:_____**State:** _____**Zip Code:**_____

LAST DAY OF CARE: _____

NEW PROVIDER INFORMATION**:**

Name: _____

Address: _____

City:_____**State:** _____**Zip Code:**_____

FIRST DAY OF CARE: _____

NEW PROVIDER SCHEDULE OF CARE INFORMATION: (Please identify the days and hours a week your children will need childcare)

Name of Child(ren)	Days Children are in Care (Check all that apply)							Hours Children are in Care	
	SUN	MON	TUE	WED	THU	FRI	SAT	From	To
1.									
2.									
3.									
4.									

Please Fax or Email to:

CHILD CARE AWARE® of AMERICA
1515 N. Courthouse Rd, 2nd Floor
Arlington, VA 22201
Fax: (703) 341-4103
msp@usa.childcareaware.org