CHILD CARE AWARE® of AMERICA MILITARY 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 Child 7are Standards

✸CHILD CARE AWARE® Of AMERICA Military : YY5gg]gHUbW Requires Notification Fifteen f%) 8ays Prior To Ending Child Care Services, regardless of who initiates the termination. When WfYa ust be terminated sooner, please contact CHILD CARE AWARE® of AMERICA A]`]hUfmDrogram 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 Military 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 fYei]fYX supporting documents for the new provider VYZcfY 7< =@8 75F9 5K5F9¤ cZ5A 9F=75 k]``]ggi Y fY]a Vi fgYa Ybhg"

TODAY'S DATE: ______________________

SPONSOR INFORMATION:

Family Identification Number: ____________________________

Name: ____

Sponsor/Spouse Phone Number: ______________________

Address: ___________________________________

City: ________________ State: ___________ Zip Code: ______________

☐ Check If New Address/Phone Number

CHANGE OF PROVIDER APPLIES TO FOLLOWING CHILD(REN):

Child's Name:	**Date of Birth**
______________________	________________
______________________	________________
______________________	________________
______________________	________________

FORMER PROVIDER INFORMATION:	**NEW** PROVIDER INFORMATION:
Name: ______________________	**Name:** ______________________
Address: ______________________	**Address:** ______________________
City: __________ **State:** _____ **Zip Code:** ________	**City:** __________ **State:** ______ **Zip Code:** _______
LAST DAY OF CARE: ______________________	**FIRST DAY OF CARE:** ______________________

NEW PROVIDER SCHEDULE OF CARE INFORMATION: (Please identify the days and hours a week each child will need child care)

Name of Child	**Days Child Is In Care (Check all that apply)**							**Hours Child Is 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
Email: msp@usa.childcareaware.org
Phone: 1-800-424-2246
Fax: 703-341-4103
www.childcareaware.org