Provider Name:

Provider Information Change Form

☐ **CHANGE** ☐ **REACTIVATE Effective Date**_____ ☐ **INACTIVE Effective Date**_____

TIER CLASSIFICATION: ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 2 Mixed**

Provider Information: (PRINT ONLY THE CHANGES)

Name: _____

Address: _____ Apt #: ____

City: _____ Zip:_____

Telephone Number: (_____)_____

Cell Phone Number: (_____)_____

Email Address: _____

Second or substitute caregiver(s) changes:

List name(s):_____

_____

Phone(s): _____

_____

(For Rel. Care or Alt Care providers please submit a BCI for all listed)

Outside of home employment changes:

Date started:_____

Days/Hours of work: Days _____

Hours from _____ to _____

Place of work:_____

Work phone: _____

_____

What hours care is provided:

from to

Days of week day care is provided:

☐ Sunday ☐ Thursday
☐ Monday ☐ Friday
☐ Tuesday ☐ Saturday
☐ Wednesday

Meals claimed:

A. Breakfast ☐ _____ to _____
B. A.M. Snack ☐ _____ to _____
C. Lunch ☐ _____ to _____
D. P.M. Snack ☐ _____ to _____
E. Dinner ☐ _____ to _____
F. Eve. Snack ☐ _____ to _____

(minimum of **2 hours** between meal / snacks required)

Alternate meal times/days/shifts: (optional)

A. Breakfast ☐ _____ to _____
B. A.M. Snack ☐ _____ to _____
C. Lunch ☐ _____ to _____
D. P.M. Snack ☐ _____ to _____
E. Dinner ☐ _____ to _____
F. Eve. Snack ☐ _____ to _____

Specify alternate days:_____

I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Signature of provider:	**Date**	**Signature of sponsor representative:**	**Date:**

This institution is an equal opportunity provider.