

INFORMATION CHANGE FORM

Provider Name _____ Date _____

ⒸChange of Address/Phone Number/Name

ⒸNew Address _____
ⒸNew Phone # _____ ⒸNew Name _____
ⒸHealth Ordered Date _____ ⒸNew Fire Date _____
ⒸDES Expiration Date _____ ⒸDHS Expiration Date _____

ⒸRe-Tier When Moved

District _____ School _____ % Verified _____ Date _____
From: ⒸTier I by Ⓒsch Ⓒ\$ or ⒸCen ⒸMixed ⒸTier II
To New Status: ⒸTier I by Ⓒsch Ⓒ\$ or ⒸCen ⒸMixed ⒸTier II
ⒸNeed Income Verification by _____
ⒸWaiting on census _____ ⒸWaiting on parent information (mixed) _____

ⒸChange of Status

From: ⒸDES ⒸDHS ⒸAA
To New Status: ⒸDES ⒸDHS ⒸAA
ⒸFingerprints taken: _____
ⒸNew Health Date: _____ ⒸNew Fire Date _____
ⒸNew Expiration Date _____ ⒸDES Expiration Date _____

ⒸChange of Active/Inactive

ⒸActive Date _____
ⒸInactive Date _____

ⒸChange of Schedule for Reviews and/or Fire

Ⓒ 28 Day Date _____
ⒸTri 1 Date _____
ⒸTri 2 Date _____
ⒸTri 3 Date _____

ⒸOff Program Changes

ⒸOff Program Date _____ Off State List Date: _____

*Note: Be sure to put in the provider's name, check the section above to designate the type of change, and fill in the date.

Each person who moves has to re- tiered before a new month's menus is processed.

Area Coordinator _____

White Copy = Office

Yellow Copy = Area Coordinator

10/14