Ohio Department of Education – Child and Adult Care Food Program
Family Child Care
PROVIDER OCTOBER TRANSFER FORM

If a provider wants to change sponsors, this transfer form must be used. If a provider has submitted one or more claims in the previous program year (October 1 – September 30) the current sponsor must sign and date this form on or before October 31st in order for the transfer to be approved.

To the provider: All sponsors operate under the same rules and regulations required by the Child and Adult Care Food Program.

PROVIDER INFORMATION

PROVIDER NAME:

ADDRESS:

CURRENT SPONSOR:

NEW SPONSORING ORGANIZATION:

PROVIDER SIGNATURE / DATE (optional):

CURRENT SPONSOR COMPLETE THIS SECTION

Check One: Professional certified type B ____ Agency Inspected Limited type L ____

Alternate Approval ____ Type A ____ Foster ____ Military ____ Other _____

At this time, provider is in good standing with this agency with no unresolved action pending (unresolved action includes but is not limited to attending required annual training, current suspension, investigation in progress, unpaid debt to sponsor, termination for misclaims).

Have you initiated any corrective action toward this provider or are there any outstanding corrective actions?
No____ Yes ____ (If Yes, explain)

Comments:

Authorized Sponsor Representative (please print) _____Date_____

Authorized Sponsor Representative Signature _____Date_____

STATE AGENCY ONLY

☐ Approved ☐ Denied

Authorized Signature_____ Title_____ Date_____

Ohio Department of Education – Child and Adult Care Food Program
Family Child Care
PROVIDER CHANGE REQUEST FORM

A provider may change sponsors during the current program year only if this provider has not claimed with their sponsor from October 1st of the current year to the date of the requested change.

To the provider: All sponsors operate under the same rules and regulations required by the Child and Adult Care Food Program.

PROVIDER INFORMATION

PROVIDER NAME:

ADDRESS:

CURRENT SPONSOR:

NEW SPONSORING ORGANIZATION:

PROVIDER SIGNATURE / DATE (optional):

CURRENT SPONSOR COMPLETE THIS SECTION

Check One: Professional certified type B ____ Agency Inspected Limited type L ____

Alternate Approval ____ Type A ____ Foster ____ Military ____ Other _____

Are there any unresolved issues with this provider? Yes_____ No_____ (If yes, explain)

Have you initiated any corrective action toward this provider or are there any outstanding correction actions?
Yes _____ No _____ (If yes, explain)

CURRENT SPONSOR COMPLETE THIS CERTIFICATION SECTION

Provider Name: _____

I certify that the above provider has not claimed from October 1 of this current program year to the date of this requested change.

Authorized Sponsor Representative (print name)_____

Authorized Sponsor Representative Signature_____Date_____

STATE AGENCY ONLY

☐ Approved ☐ Denied

Authorized Signature_____ Title_____ Date_____