Community Coordinated Care for Children, Inc.

3500 West Colonial Drive, Orlando, FL 32808
(407) 522 – 2252
www.4cflorida.org

TRANSFER REQUEST FORM

Date: ______/______/______

Parent Name: ____ SSN: ______-_______-______

Parent Address, City, State, Zip: ____

Employer: _______________________________________ Phone # to be reached: _______________________________

I would like to request a transfer for the following children:

Name: ______________________________________ Birth date: ____/____/____ Last date attended: ____/____/____

Name: ______________________________________ Birth date: ____/____/____ Last date attended: ____/____/____

Name: ______________________________________ Birth date: ____/____/____ Last date attended: ____/____/____

Name: ______________________________________ Birth date: ____/____/____ Last date attended: ____/____/____

FROM: ____
CURRENT PROVIDER - NAME & ADDRESS

TO: ____
NEW PROVIDER - NAME & ADDRESS

EFFECTIVE DATE OF TRANSFER: _____/_____/_____

PLEASE NOTE:

- Transfer request must be completed by parent/guardian receiving 4C services.
- Your zero balance letter must be submitted with this form; Zero balance must be verified prior to processing transfer.
- You must speak to your new provider and verify that there is space available for your child(ren) before requesting a transfer.
- Transfers cannot be back-dated; Transfer requests received after 4 pm will be made effective the following business day.
- A copy of your transfer paperwork will be faxed to your new provider and mailed to you.

My signature on this transfer request form indicates that I requested and approve of this transfer.

____
PARENT SIGNATURE **DATE**

4C USE ONLY:

Zero Balance at ____ verified by ____________________________________.
PROVIDER NAME EMPLOYEE NAME

Transfer done in EFS; faxed to provider; copy mailed to parent by: ____
COUNSELOR NAME

Date: ______/______/______ Time: ____________________