Failure to report service need changes within **TEN (10)** calendar days may result in termination of services and you will be required to repay funds to the State of Indiana. You **MUST** report when your employment stops, school/training program stops, IMPACT activity stops, family status changes or your address changes.

 **ALL necessary verification/documentation MUST be submitted with completed form.**

**Parent Name** (print): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #: XXX-XX-\_\_\_\_\_\_\_\_\_**

* My Impact activity ended on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* My job or school/training ended on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ please check one of the following:
	+ I would like to job search.
	+ I have started a new activity
	+ I do not have a new activity

**Important: *An update appointment is required within 10 days or CCDF services will be terminated.***

***Must Submit verification from last employer that job has ended or school has ended***

* I adopted my foster child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Child’s name) on \_\_\_\_\_\_\_\_\_\_\_\_\_\_(date).
* Please close my case. I no longer need childcare assistance as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* A family member has left my home

Name of person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I have a new family member in my home. ***Identity verification is needed. Complete parent worksheet. You may need to complete an income update within 10 days.***

Name of person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is childcare needed for this individual? \_\_\_Yes \_\_\_ No

* I am changing to a new child care provider. Date to Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of new provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***New Provider (805) form must be completed by provider and submitted with this form.***

***Provider changes must be submitted by Thursday before 12:00 PM. for changes to start the following Monday.***

 ***Any provider changes submitted after 12:00 PM on Thursday will not go into effect until the second Sunday.***

* I have moved, my new contact information is ***(must provide verification, utility bill, lease, I.D. with new address)***:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zipcode Phone #

* Other Changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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