Family Services
2536 Countryside Blvd, Suite 500
Clearwater, FL 33763
(727) 400-4411 www.elcpinellas.net
FAX (727) 400-4486

SCHOOL READINESS CHILD TRANSFER REQUEST
One Form Per Child

TODAY'S DATE: _____

PARENT/GUARDIAN NAME *(Required)* _____ SSN: _____

CHILD'S NAME Needing Transfer *(Required)*_____

This form must be submitted to the Family Services Department 72 HOURS prior to your child's start date with the new provider. Once this form is reviewed by an ELC Specialist, your enrollment notices will be sent to the new provider in TWO (2) BUSINESS DAYS. If you have not received confirmation of the enrollment by mail within ONE (1) WEEK of your submission, then please call (727) 400-4411. PLEASE ALLOW SUFFICIENT TIME FOR PROCESSING.

THIS BOX TO BE COMPLETED BY CURRENT PROVIDER ONLY

CURRENT PROVIDER'S NAME *(Required – Please Print)*	
PROVIDER STAFF SIGNATURE *(Required)*	
PROVIDER STAFF PRINTED NAME *(Required)*	
PROVIDER EIN# or LAST FOUR SSN# *(Required)*	
FEES OWED (CO-PAYMENT ONLY)	[ ] Yes [ ] No
CO-PAYMENT AMOUNT OWED	$

THIS BOX TO BE COMPLETED BY NEW PROVIDER ONLY

NEW PROVIDER'S NAME *(Required – Please Print)*	
CHILD'S START DATE *(Required)*	
NEW PROVIDER'S STAFF SIGNATURE *(Required)*	
PROVIDER EIN# or LAST FOUR SSN# *(Required)*	
How would you prefer to receive the enrollment notices?	[ ] Mail [ ] Portal

I understand that my current provider must sign and complete the first section to confirm that all co-payments are paid. The second section indicates the new provider that I have selected, along with the start date we have both agreed upon. I am aware that if I move my child prior to submitting this transfer request to the Family Services Department, then I will be responsible for paying the full cost of care.

_____ _____
Parent Signature Date