THE WORKING PARENTS ASSISTANCE PROGRAM

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TERMINATION OF CARE AND PROVIDER CHANGE FORM

SECTION I CLIENT INFORMATION (To be completed by WPA client)

(Please print)
FIRST NAME LAST NAME:

ADDRESS:

TELEPHONE NUMBER: CASE MANAGER NAME:

SECTION II PAST PROVIDER INFORMATION (To be completed by the provider that you are leaving)

NAME OF PROVIDER:

PROVIDER SITE: PHONE NUMBER:

CHILDREN LEAVING PROVIDER: LAST DAY OF CARE:

SIGNATURES

DID THE PARENT GIVE A TWO WEEK NOTICE?		YES	NO	
IF NO, DID YOU WAIVE THE 2 WEEK NOTICE?		YES	NO	

By signing below both parties agree that a) a two week notice was given by the client, b) no payments are owed to the provider by the client, or c) payments are owed to the provider by the client and a payment plan has been executed and d) the information given above is true and complete.

PROVIDER'S SIGNATURE: **CLIENT'S SIGNATURE:**

SECTION III NEW PROVIDER INFORMATION

NAME OF PROVIDER: START DATE:

ADDRESS OF PROVIDER: PHONE NUMBER:

THANK YOU! PLEASE ALLOW 2 WEEKS FOR THE CHANGE TO BE MADE.