



## Request to Transfer Active School Readiness Services

### SECTION I: To be completed the Parent requesting the transfer.

This form confirms the request to transfer Active School Readiness services to another county. The coalition in the county the Parent is leaving must change the status of the Parent’s record in the Parent Portal which will enable the Parents to update their address and county of residence. Resubmitting the Portal application with the address / county changes will give the coalition in the new service area access to the record.

Parent Name: \_\_\_\_\_ Transfer from \_\_\_\_\_ County; Last date of services: \_\_\_\_\_

My child(ren) are attending: \_\_\_\_\_. I wish to transfer my School Readiness services to \_\_\_\_\_ County for each child listed below.

Child/ren: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My signature confirms that the information above is true and correct to the best of my ability. I also authorize the coalition to share information with the coalition in my new service area as needed to complete the transfer process.

Have you identified a Child Care Provider in Alachua County?  Yes  No

If no, complete the attach form to receive a listing in our area.

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Office Use Section

Notify Coalition

Update Portal Application /  N/A

Coalition Staff: \_\_\_\_\_ Date: \_\_\_\_\_

### Resource and Referral Child Care Provider Request

Please use the <u>Tab Key</u> to move from box to box ( <u>Don't use the Enter Key</u> )			
* Indicates a <u>Required Field</u> , failure to fill out all required fields can result in an unsuccessful request submission			
1. Have you received services through ELCAC previously?		Yes	No
a. If so, what program(s) and dates: _____			
2. Are you in need of financial assistance to pay for child care?		Yes	No
* 1 <sup>st</sup> Parent Last Name	* 1 <sup>st</sup> Parent First Name	MI	DOB
* 2 <sup>nd</sup> Parent Last Name	* 2 <sup>nd</sup> Parent First Name	MI	DOB
*Residence Address:		*City:	*State: *Zip:
Mailing Address:		City:	State: Zip:
* Home Phone:	Work Phone:	Fax:	*E-Mail:
<b>Family Size:</b>			
Along with the list of child care providers you will receive additional information to help you locate quality child care how would like to receive my information:			
*Care Zone Zip Code: (Choose at least two zip code areas)			
*Reason For Care:			
*House Hold:			
*Referred By:			
*Problem Finding Care:			
*Relationship to Child:			

<b>First Child *Last Name:</b>		<b>*First Name:</b>	<b>*DOB:</b>	<b>Sex:</b>		
				Male	Female	
Childs School (If school age)						
Transportation To School:			From School:			
<b>*Hours</b> of Care needed <b>From:</b> <b>To:</b>						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>Second Child *Last Name:</b>		<b>*First Name:</b>	<b>*DOB:</b>	<b>Sex:</b>		
				Male	Female	
Childs School (If school age)						
Transportation To School:			From School:			
<b>*Hours</b> of Care needed <b>From:</b> <b>To:</b>						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

**\* For Additional Children: Please check this box and enter on pages 3/4. Curriculum: (Optional)**

High Reach		High Scope		Galileo	
Creative Curriculum		Montessori		DLM Early Childhood Express	
Bank Street		Religious (All)		Beyond Centers & Circle Time	
Waldorf		Wee Learn		Other	

**Enhanced Schedules:**

24 Hour Care		Emergency/Temporary Care		School Year	
After School		Evening Care		Summer Only	
Before School		Full Time		Vacation/Holidays	
Drop-In Care		Part Time		Weekend	

**Special Needs: (Optional) Note Child's initials in box**

Add/Adhd		Medically Challenged		Spch/Lang Delay	
Autism Spectrum Disorders		Mental Disability/Delay		Vision Impairment	
Behavioral Disorder		Physical disability/Delay		Hearing Impairment	
Developmental Delay		Seizure Disorder			

**Environment: (Optional)**

Bilingual	<input type="checkbox"/>	Sick Child	<input type="checkbox"/>
Near Public Transportation	<input type="checkbox"/>	Sign Language	<input type="checkbox"/>
No Pets	<input type="checkbox"/>	Smoke Free	<input type="checkbox"/>
No Pool	<input type="checkbox"/>	Teen Parent Program	<input type="checkbox"/>
Transportation by provider	<input type="checkbox"/>	Walking distance to school	<input type="checkbox"/>

**\*Program: (You MUST choose one or more)**

Child Care Center	<input type="checkbox"/>	Pre-K Early Steps	<input type="checkbox"/>
Family Child Care Home	<input type="checkbox"/>	School Age Program	<input type="checkbox"/>
Headstart	<input type="checkbox"/>	VPK Summer	<input type="checkbox"/>
Large Family Child Care	<input type="checkbox"/>	VPK School Year	<input type="checkbox"/>

**After you click the Submit button on page 4, an ELCAC representative will send a confirmation letter which you need to print for your records.**

**Complete this section for additional children then press submit**

<b>Third Child</b>		<b>*First Name:</b>	<b>*DOB:</b>	<b>Sex:</b>		
<b>*Last Name:</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Male	Female	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Childs School (If school age)						
Transportation To School:			From School:			
<b>*Hours</b> of Care needed <b>From:</b> <b>To:</b>						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Fourth Child</b>		<b>*First Name:</b>	<b>*DOB:</b>	<b>Sex:</b>		
<b>*Last Name:</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Male	Female	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Childs School (If school age)						
Transportation To School:			From School:			
<b>*Hours</b> of Care needed <b>From:</b> <b>To:</b>						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Fifth Child</b>		<b>*First Name:</b>	<b>*DOB:</b>	<b>Sex:</b>		
<b>*Last Name:</b>				Male	Female	
Childs School (If school age)						
Transportation To School:			From School:			
<b>*Hours</b> of Care needed <b>From:</b> <b>To:</b>						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>Sixth Child</b>		<b>*First Name:</b>	<b>*DOB:</b>	<b>Sex:</b>		
<b>*Last Name:</b>				Male	Female	
Childs School (If school age)						
Transportation To School:			From School:			
<b>*Hours</b> of Care needed <b>From:</b> <b>To:</b>						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

**OPTIONAL:** The state of Florida sometimes asks for information about people seeking child care such as do they work or are they in school or training. If you would like to help us with providing this information please complete the following fields.

<b>Employers Name:</b>		<b>Phone:</b>		
<b>Employers Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Training Facility:</b>		<b>Phone:</b>		
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>