

## VPK Provider Change of Address

**Complete this form and follow the instructions for faxing to the  
Provider Services Department immediately**

**Provider Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Effective date as shown on new DCF license:** \_\_\_\_\_

**Previous address (street, city, state, zip):** \_\_\_\_\_  
\_\_\_\_\_

**New address (street, city, state, zip):** \_\_\_\_\_  
\_\_\_\_\_

**Printed name and signature of Program Owner:** \_\_\_\_\_  
\_\_\_\_\_

**For VPK transition to your new address, submit the following documents to:**

**Alecia Coitrone, Provider Contracts Coordinator – fax (386) 323-2426  
Telephone (386) 323-2400 ext. 186**

**Jenni Riccio, Provider Contracts Coordinator – fax (386) 323-2426  
Telephone (386) 323-2400 ext. 139**

- | <u>Initial</u> | <u>Form submitted</u>  |
|----------------|--|
| _____          | New AWI VPK 10 form  |
| _____          | New AWI VPK 11B form (showing start date at new address.) (Should end date, program hours or non-instructional days change assure they changes are documented and submit for approval) |
| _____          | New AWI VPK 20 Provider Agreement  |
| _____          | New DCF License  |
| _____          | New Certificate of Insurance   |
| _____          | New Payment Selection Form (voided check must show the new provider address)   |
| _____          | New W-9 form   |