

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 11 form (showing start date at new address, maintain end date, maintain program hours and non-instructional days) |
| _____ | 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 |