Mississippi Child Care Payment Program
Request for a Change in Provider Form

Parent Name:____

Parent Address: ____

City ____________________________ Zip Code: ___________________ Parent SSN#:_____________

Child(ren) Name(s): ____

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____

Current Provider & Center Name:____

Current Provider Address: ____ City: ______________

***Provider Signature: ________________________________Last Date of Attendance: ____________

Were you provided with a 2 week notice? ☐Yes ☐No Last day of two week notice: ______________

*(***Provider: By signing above, you are acknowledging that this parent does not owe any* ***CoPayment*** *fees. DECCD cannot enforce the collection of any fees other than CoPayment fees, such as tuition, activity fees, etc.)*

New Provider Name: ____

New Provider Address: ____ City: _______________

Provider Signature: ___________________________________First Date of Attendance*: ___________
**You are not eligible for payment until the completion of a two week notice period to previous provider.*

____ _______________________________
Parent Signature Date

Return Form to:

Mail to: DECCD
P.O. Box 352
Jackson, MS 39205

Email to: ccpayment@mdhs.ms.gov
Fax to: 601-359-4422