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): _____

_____

_____

_____

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