

Mahoning County Department of Job and Family Services
CHANGE FORM FOR CHILD CARE SERVICES

* You are required to report all changes within 10 days prior to or during the current service week *
** Changes are effective the day after they are entered into the Child Care System **
*** Changes cannot be made without requested information ***

Name: _____

Case Number or Social Security Number: _____

Telephone Number: _____

1. New Address or Telephone number: _____

2. New Place of Employment: _____ Hire Date: _____

Address: _____

Hourly rate of pay: _____ Average # of hours/week: _____

Days of the week scheduled to work (please circle): M, T, W, Th, F, Sa, S

Times: _____

End date of previous employer: _____

**please submit an Employer Statement (must be on their letterhead) to verify past and present employment info listed above and submit all pay stubs received to date*

3. Change in Employment Earnings and/or Hours: () decrease () increase

New hourly rate: _____ Hours Per Week: _____ Overtime: _____

**please submit current pay stubs or a statement from your employer to verify the change*

4. Change in Work Schedule: Effective date: _____ Lay-off Date: _____

**please attach employer letter to verify new work schedule*

5. Change in School Schedule: Effective date: _____

**please attach new school schedule*

6. Change in Household Members: (All persons in household must be reported):

Name: _____ Date of Birth: _____

7. Change in Provider:

Term Old Provider(s): _____ Last day: _____

New Provider: _____ Start date: _____

8. Need second Provider:

Second Provider: _____ Start date: _____

Child(ren): _____

Days and Times: _____

**please attach employer letter to verify new work schedule*

Signature: _____ Date: _____