SCHOOL READINESS PROGRAM
TRANSFER REQUEST FORM

Please note that a zero balance letter MUST be attached to this transfer request from your current provider in order to be processed.

☐ Client pick up ☐ Mail to provider/parent

Date: _____

Parent Name: _____ Parent SS#: _____

Home Address: _____

Phone # to be reached during weekday's: _____ Alternate Phone: _____

Employer Name: _____

NOTE: Only list children being transferred. *(Use reverse side if needed).*

CHILD #1

Name _____ Zero Balance? ___Yes ___No

S.S.# _____ Birthdate: _____ Last Day Attended _____

Effective date of transfer: _____

CHILD #2

Name _____ Zero Balance? ___Yes ___No

S.S.# _____ Birthdate: _____ Last Day Attended _____

Effective date of transfer: _____

Child #3

Name _____ Zero Balance? ___Yes ___No

S.S.# _____ Birthdate: _____ Last Day Attended _____

Effective date of transfer: _____

Transfer From: _____ Address: _____

Transfer To: _____ Address: _____

Have you done their registration? ☐ Yes ☐ No

Parent Signature _____ **Date** _____

Zero Balance Verified: _____ Transfer Effective Date: _____

Completed by _____ Date _____

Effective 2.16

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