



ZERO BALANCE VERIFICATION FOR TRANSFERS

Date: _____

Parent's Name: _____

Child's Name: _____ SS#: _____

Child's Name: _____ SS#: _____

Child's Name: _____ SS#: _____



Provider's Name/Program Name: _____

Phone Number: _____ Vendor ID# _____

Last day child (ren) attended: _____

_____ Title: _____

Authorized Representative Signature

Print Name

Office Use Only:

Zero balance confirmed on: _____ @ _____ am /pm by: _____

Spoke with: _____

*****PLEASE MAKE COPIES AND KEEP FOR YOUR RECORDS*****