State of Illinois
Department of Human Services - Bureau of Child Care and Development

REQUEST FOR PROVIDER ADDRESS CHANGE INFORMATION

Provider I.D. #: _____

Provider's Name & Address

Date of Notice: _____

Caseload Code: _____

Clients: _____

Clients: _____

Clients: _____

Return this form with the information we have requested to the address listed below.

Provider's Old Address			
Address:	City:	State:	Zip Code:
County:	Phone Number:		

Provider's New Address			
Address:	City:	State:	Zip Code:
County:	Phone Number:		
Mailing Address, if different than above.			
Date this address is to take effect:			

Month Day Year

BOTH THE PROVIDER AND CLIENT MUST SIGN BELOW IN ORDER FOR US TO MAKE THIS CHANGE!
(If you provide care for more than one client, all clients must sign.)

I certify that this change is known and correct.

Provider Signature: _____ Date: _____

I certify that this change is known.

1. Client Signature: _____ Date: _____

2. Client Signature: _____ Date: _____

3. Client Signature: _____ Date: _____

If you have any questions, please contact your child care specialist at: _____

Comments:

Print Form Reset Form