Elder Affairs FLORIDA

CHANGE OF INFORMATION

Note: Any change of information to current Provider Application package **not** listed below will be submitted by:
Mailing a copy of current Application and/or Schedule A to the ACFP office with changes denoted in ***red ink.***

Instructions: Complete section #1 and any/all appropriate sections that reflect changes to current contract, obtain authorizing signature and mail.

1. PROVIDER INFORMATION **Effective date of change: _____ ACFP Contract # _____**

2. POINT OF CONTACT (POC) INFORMATION:
Current POC name with ACFP: _____
New authorized POC's name: _____
New mailing address for POC: _____ ZIP_____
POC's date of birth: _____
New street address for POC: _____
New Telephone number for POC: ( ) _____
New Fax number for POC: ( ) _____
New E-mail address for POC:

3. INSTITUTION INFORMATION
Current Institution name with ACFP: _____
New legal name of Institution: _____
New mailing address of Institution: _____ ZIP_____
New street address of Institution: _____
New Telephone number of Institution: ( ) _____
New Fax number of Institution: ( ) _____
New F.E.I.D. number of Institution: _____
Please submit a copy of legal documentation of name and/or F.E.I.D. number change.
Tax exempt status. Describe: _____

4. BOARD PRESIDENT OR AUTHORIZED DESIGNEE INFORMATION
Name of new Board President or Authorized Designee: _____
Address of new Board President or Authorized Designee: _____
_____ZIP_____
Tele: ( ) _____ Fax: ( ) _____ DOB:_____

5. CENTER/SITE INFORMATION:
Note: To add a new center/site, call ACFP office (850) 414-2059 or (850) 414-2122, if deleting a center, complete the following:
Name of center as appears on Schedule A: _____
New name of this center/site: _____
New mailing address of this center/site: _____
_____ ZIP_____
New street address of this center/site: _____
This Center's/site's new/renewed ADC license capacity: _____ New/renewed license expiration date: ____
Please submit copy of new ADC license(s) or "approval letter from AHCA" until official certificate is received.

6. METHOD OF CLAIM SUBMISSION Change to: Fax or Mail

7. SIGNATURE AUTHORITY INFORMATION
The following person(s) *no longer* have signature authority: (Please print or type)
_____ _____
_____ _____

The following person(s) are *granted* signature authority: (Please print or type)

_____ ___ monthly claim vouchers ___ vendor contracts
Name/Position Title ___ other (list) _____

_____ ___ monthly claim vouchers ___ vendor contracts
Name/Position Title ___ other (list) _____

_____ _____
Signature of Institution's current Board President or Authorized Designee **Title**