

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 <u>add</u> 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) <u>no longer</u> have signature authority: (Please print or type) _____ _____ The following person(s) are <u>granted</u> signature authority: (Please print or type) <table style="width:100%;"> <tr> <td style="width:50%;">Name/Position Title</td> <td style="width:50%;"> <input type="checkbox"/> monthly claim vouchers <input type="checkbox"/> vendor contracts <input type="checkbox"/> other (list) _____ </td> </tr> <tr> <td>Name/Position Title</td> <td> <input type="checkbox"/> monthly claim vouchers <input type="checkbox"/> vendor contracts <input type="checkbox"/> other (list) _____ </td> </tr> </table>		Name/Position Title	<input type="checkbox"/> monthly claim vouchers <input type="checkbox"/> vendor contracts <input type="checkbox"/> other (list) _____	Name/Position Title	<input type="checkbox"/> monthly claim vouchers <input type="checkbox"/> vendor contracts <input type="checkbox"/> other (list) _____
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Signature of Institution's current Board
president or Authorized Designee

Title