Confirmation of
Change of Provider Information

Provider Name: ______________________________________ **Date:** ____/____/_____

Provider's ID #: ______________

Provider Meal Schedule

Breakfast		AM snack		Lunch		PM snack		Dinner		Eve Snack	
Start	Finish	Start	Finish	Start	Finish	Start	Finish	Start	Finish	Start	Finish

Days of Operation __M __Tue __W __Th __F __Sa __Su

Hours of Operation:

Day: Open __ : __ am / pm Close __ : __ am / pm

Night: Open __ : __ am / pm Close __ : __ am / pm

Address: ____

Is this a new Address? No ☐ **Yes** ☐ **Date of Move:** ____________________

Phone: _________________________ **Alternate phone:** ______________________

Effective date of changes: ____/____/____

You must notify the food program of any changes in your child care schedule, location and contact information.

Please review the above information carefully to ensure that it is correct.

If you find any information that needs to be changed, please notify us within **5 days**. The above information will remain in effect until further notice.

If you have any questions, please contact the Healthy Food Program at 773-564-8861.

Provider's Signature: _________________________________ **Date**_________________

Staff Signature:_______________________________________ **Date**_________________