Temporary Termination Request

Early Learning Coalition of Miami-Dade/Monroe

OFFICE OF **Early Learning** — LEARN EARLY. LEARN FOR LIFE.

Send completed form to Transfers Department by fax (786-275-5180) or email (transfers@elcmdm.org)
ATTN: TRANSFER UNIT

Please read, complete in full sign, and return. Both parent's and provider's signatures are required.
This form must be returned at least 72 hours before the temporary termination is needed.

INSTRUCTIONS:

1. The completed request form must be signed by the parent and provider and submitted to the Coalition at least 72 hours before the temporary termination is needed. If request is submitted after the temporary termination date, the parent will be responsible for any charges that are incurred prior to the Coalition approving the request.

2. It is the parent's responsibility to have their current provider sign the request form to ensure both parent and provider are aware of the requested dates of absence.

3. **It is the parent's responsibility to ensure their redetermination is completed timely.** If your redetermination date occurs during the period of temporary termination, you must ensure that you return your packet and complete your redetermination at least 30 days prior to your termination date. **The Coalition will not pay for any services incurred after your termination date if you have not re-established your eligibility.**

4. The parent **must contact the Coalition prior to returning the child to care**. Failure to do so could result in the loss of child care funding and the need to reapply to the Wait List.

5. Please note that the Coalition will **NOT** pay the provider for the child's slot during the temporary termination.

6. The Coalition cannot guarantee that the child will be able to return to the same provider or that funding will be available when the child returns.

7. If you have any questions, please contact the Coalition at info@elcmdm.org

Reason for temporary termination (required):

Child(ren)'s Name (Last Name, First Name)	Provider	Days Out of Care		Provider Signature	Date
		From	**To**		

_____
Parent/Guardian Name

_____
Social Security number

_____
Parent/Guardian Signature

_____
Date