

PROVIDER REQUEST FOR TERMINATION (NON-PAYMENT OF PARENT FEE)

I. General Information

Date:	
Name of Provider/Facility:	Provider Number:
Physical Address: <i>(Street, City, State, Zip Code)</i>	Telephone Number:

II. Parental Information

Parent's Name:			
Total Outstanding Amount: \$	Parent Fee: \$	NSF Charges: \$ Check No:	Late Pick-up Fee: \$

III. Client Information

Child's Name (Last, First)	Client Number

IV. Certification

I certify the parent listed above has failed to pay the assessed parent fee or other Workforce Solutions allowable charges and I am requesting the immediate termination of their services. I acknowledge that upon receipt of this form **Workforce Solutions will terminate services for this parent and child(ren)**. I further acknowledge that **Workforce Solutions will NOT reimburse me for any outstanding amounts.**

Provider Authorized Representative

Date

For Office Use Only:

<i>Date Received:</i>	<i>Accounts Payable Specialist:</i>
<i>Date Entered into FACS:</i>	<i>FACS NO.</i>