



**Department of Public Health and Social Services**  
 Division of Children's Wellness ♦ Bureau of Child Care Services  
 130 University Drive Rm.15, Mangilao, Guam 96913  
 Telephone 671-735-7256 / 671-735-7344 ♦ Fax 671-735-7165  
**Request for Client and Provider Separation Clearance**

Client/Case Name:	Case / Social Security Number:
Provider Name:	Elig. Specialist:

Change of child care provider shall only be authorized when this clearance form is completed by the client and the provider. This document must be submitted to Department of Public Health and Social Services, Division of Public Welfare, Bureau of Economic Security, as soon as possible.

I, \_\_\_\_\_, certify that the above CCDF participant:

Child name: _____	Date of Birth: _____
Child name: _____	Date of Birth: _____
Child name: _____	Date of Birth: _____
Child name: _____	Date of Birth: _____
Child name: _____	Date of Birth: _____
Child name: _____	Date of Birth: _____
Child name: _____	Date of Birth: _____

has current or outstanding child care service obligation.

Remarks: \_\_\_\_\_  
 \_\_\_\_\_

has NO current or outstanding child care service obligation. I authorize the participant to choose another child care provider effective \_\_\_\_\_.

I understand that it is a federal crime punishable by fine or imprisonment, or both, to knowingly make any false statements.

Concurred by:

_____	Date: _____
(Provider's Signature)	
_____	Date: _____
(Client Signature)	

**FOR OFFICE USE**

Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
 (BCCS Staff)

Disposition:  Approved  Disapproved

Remarks: \_\_\_\_\_  
 \_\_\_\_\_

Eligibility Specialist: \_\_\_\_\_ Date: \_\_\_\_\_  
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