

Resource Care Enrollment/Change Form

New Change Close

_____ **Provider Number**

Name of Provider

Physical Address

Town/City

State

Zip

Mailing Address (if not the same as above)

Town/City

State

Zip

Social Security Number

Phone

Email Address

For District Office Only

Status

- Initial License
- Permit
- Relative Care
- Renewal
- Revision

Service

- Adoption Subsidy Only
- Crisis Care
- Emergency
- General
- Initial Clothing Allotment
- Non-recurring Adoption
- Relative Care
- Respite
- Specialized

Start Date _____

End Date _____

Signature of Provider

Date

District Office/Agency Worker

Date

District Office/Agency

Provider Relations Unit

Date

Instructions to the "Resource Care Enrollment/Change Form"

PURPOSE:

The "Resource Care Provider Enrollment/Change" is used to collect information about individuals who provide placement, adoptive parents applying for adoption subsidy, or individuals who apply to be licensed or certified for payment. It is also used to change information about foster family, adoptive family or Relative Care.

INSTRUCTIONS:

Form 2104 is a one-page form completed by the provider, Foster Care Worker, CPSW or the Child Placing Agency staff. For Foster Care the "Foster Family Care Worksheet" (Form 2367) or the foster parent's "Permit" (Form 2368) or "License" (form 2369) must be attached.

Provider Relations Unit staff enter the form's information on NH Bridges.

For providers to receive payment for services, enrollment must occur prior to the start of service delivery. Unsigned forms will be returned. Retain a copy for your records.

FORM COMPLETION: *Please print or type*

Indicate a new enrollment or information to be changed or closed.

For new enrollments please leave the provider number blank.

Provider Name: Enter your first and last name or the name of the agency.

Physical Address: Enter your complete address including Town/City, State, Zip Code.

Mailing Address: Enter mailing information if it is different from your physical address. *If this section is completed, all correspondence will be sent to this address.*

Enter your Social Security number (*This number must match the entry on the Alternate W-9*).

Enter your telephone number and email address.

Signature of Provider and Date.

Completed by the Resource Worker or CPSW:

Complete For District Office Only; check the appropriate status and service.

Enter the Start and End Date.

Signature and Date and enter the District Office or Agency Name.

Completed by Provider Relations Unit staff:

Enter the information in to NH Bridges and sign and date the form.

Return the original to:

Division for Children, Youth and Families Resource Worker in the District Office

RETENTION:

The Provider Relations Unit staff retains Form 2104 for as long as the provider is enrolled on NH Bridges.