Adjustment Request Form

email: payments@elcmdm.org
fax: (786) 433-3237

Facility Name:	Date:	Provider ID#:
Site Address:	Telephone #:	
	Provider Signature:	

Attendance Reimbursement Changes: ☐ Days Adjusted ☐ Rate Adjusted ☐ Both

Child's Name:	Last 4 digits of SS#:	Funding:

➡ Only indicate the additional days requested for adjustment reimbursement

Month:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	

Total Days	Family Income	Family Size
FA	Daily Fee	Total Fee

Rate Paid: $	Correct Rate (if rate change is applicable): $

Reason for Rate Adjustment: ☐ FT or PT ☐ Age Change ☐ Gold Seal Provider ☐ Licensed Provider ☐ Other

Additional Comments:

REQUIRED: Parent sign in/out forms or VPK long form and/or any other supporting documentation

FOR ELC STAFF ONLY

Received:	ELC Tracking Number:

All Required Documentation Received? ☐ Yes ☐ No	If no, when was it received?	
Was Adjustment Request Finalized? ☐ Yes ☐ No	If yes, when?	
Payment Specialist:	Adjustment Reimbursed: month year	

Additional Comments:

When completed ELC will upload the completed Adjustment Request Form to the provider portal account under the **BANKING INFORMATION** folder.