



MIAMI DADE COUNTY (J)
COMMUNITY ACTION AGENCY
HEAD START/EARLY HEAD START
TRANSFER REQUEST FORM

CHILD NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ CELLUAR #: \_\_\_\_\_

CENTER: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

SOCIAL WORKER NAME: \_\_\_\_\_ CENTER DIRECTOR: \_\_\_\_\_

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Please indicate three centers to maximize your request.

TRANSFER REQUEST TO: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
(CENTERS NAME)

REASON FOR TRANSFER: \_\_\_\_\_

IDENTIFY ANY SPECIAL NEEDS \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_

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SOCIAL WORKER FORWARDED TO: \_\_\_\_\_

CENTER DIRECTOR: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ CENTER: \_\_\_\_\_

DATE: \_\_\_\_\_ FOLLOW-UP DATE: \_\_\_\_\_

NOTE: TRANSFERS RECEIVES PRIORITY FOR PLACEMENT. THE CHILD'S FOLDER AND A HSFIS DOWNLOAD MUST BE FORWARDED TO THE CENTER DIRECTOR WHEN THERE IS A CONFIRMED VACANCY AT THE CENTER.

FORM DISTRIBUTION:

- \_\_ ORIGINAL TO RECEIVING CENTER
\_\_ FOLDER
\_\_ PARENT COPY.