**Refusal of Care**

**I: General Information**

|  |  |
| --- | --- |
| **Vendor Name:** | **License Number:** |
| **Physical Address:** | **Telephone Number:** |

**II. Customer Information**

|  |  |
| --- | --- |
| **Customer Name:** | **TWIST ID** |

**III: Reason for Refusal of Care**

|  |
| --- |
|  **Non- Payment of Parent Share of Cost** |
|  **Parent Withdrawal/ No Longer Attending**  |
|  **Other Specify Reason:** |

**III: Children Affected**

|  |
| --- |
|  **All Children** |
|  **Specific Children: List Names:** |

**Important Information:**

* Refusal of Care forms can be submitted through the vendor portal or fax to 713-974-7983 - Attention: Accounts Payable.
* Your Accounts Payable Representative will request for care to be ended upon receipt of Refusal of Care form.
* Vendors should not accept the children after the form has been submitted. Workforce Solutions will not pay for the days the child(ren) attends after the form has been submitted.
* Workforce Solutions will not reimburse vendors for any outstanding balance.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vendor Authorized Representative Date**

***Internal Use Only:***

|  |  |
| --- | --- |
| **Date Received:** | **Accounts Representative:** |
| **Date of FAC Issue Requesting Closure:** | **Issue Number:** |

