BENTON COUNTY PARENT NOTIFICATION STATEMENT

Provider Name: _____

I am requesting a variance from Benton County Human Services on my allowable capacity so that I may care for a additional child/children. I will be over my license capacity for the following time period if the variance is approved: _____ I am allowed to be overcapacity for a period of 60 days or less in a calendar year.
Please sign below to indicate that you have been informed of this variance request.

1. _____ _____
   Signature Date

2. _____ _____
   Signature Date

3. _____ _____
   Signature Date

4. _____ _____
   Signature Date

5. _____ _____
   Signature Date

6. _____ _____
   Signature Date

7. _____ _____
   Signature Date

8. _____ _____
   Signature Date

9. _____ _____
   Signature Date

10._____ _____
   Signature Date