

FDCH APPLICATION FOR PARTICIPATION FOR FAMILY DAY CARE HOMES

Child Nutrition Programs – USOE

Helping Hands, Inc.

APPROVAL TYPE: LICENSE RESIDENTIAL CERTIFICATE RELATIVE CARE ALTERNATE APPROVAL
 NEW TRANSFER CHANGE RENEWAL INACTIVE
TIER CLASSIFICATION: Tier 1 Tier 2 Tier 2 Mixed

(Office Use Only) 1) Provider's Identification Number _____		2) APPLICATION Period: From _____ 20____ To _____ 20____	
3) Provider Information: (PRINT CLEARLY) Name: _____ Address: _____ Apt #: _____ City: _____ Zip: _____ Telephone Number: (_____) _____ Cell Phone Number: (_____) _____ Email Address: _____ Date of Birth: _____		4) (Initial application only) Have you or any other member of your household ever participated with another food sponsor? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If yes , please answer the following: Name of sponsor: _____ Name of person(s) who participated: _____ Date last claimed _____ <i>(*If you stated yes, a formal transfer is required; forms are available upon request.)</i>	
5) Income eligible for Provider's own children: (Office Use) Yes <input type="checkbox"/> No <input type="checkbox"/>		6) School, Census or Income (office use) A. <input type="checkbox"/> School District: _____ Elementary School _____ Expiration date: _____ B. <input type="checkbox"/> Census Block number: _____ Expiration date: _____ C. <input type="checkbox"/> Income Expiration date: _____	
7) Holiday care provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, check holidays care is offered below</i> <input type="checkbox"/> New Year's Day <input type="checkbox"/> President's Day <input type="checkbox"/> Memorial Day <input type="checkbox"/> Independence Day <input type="checkbox"/> Labor Day <input type="checkbox"/> Thanksgiving Day <input type="checkbox"/> Christmas Day <small>(This is for our information only and NOT a preauthorization. You must still preauthorize each of these holidays if you wish to claim them.)</small>	8) Hours of care—weekdays from _____ to _____ Hours of care —weekends (optional) from _____ to _____	9) Days of week day care is provided: <input type="checkbox"/> Sunday <input type="checkbox"/> Thursday <input type="checkbox"/> Monday <input type="checkbox"/> Friday <input type="checkbox"/> Tuesday <input type="checkbox"/> Saturday <input type="checkbox"/> Wednesday	
10) Meals claimed: A. Breakfast <input type="checkbox"/> _____ to _____ B. AM Snack <input type="checkbox"/> _____ to _____ C. Lunch <input type="checkbox"/> _____ to _____ D. PM Snack <input type="checkbox"/> _____ to _____ E. Dinner <input type="checkbox"/> _____ to _____ F. Eve Snack <input type="checkbox"/> _____ to _____ (A minimum of 2 hours between the starting times of each meal/snack)		Alternate meal times/days: (if applicable) Specify alternate days/or if split shift: _____ A. Breakfast <input type="checkbox"/> _____ to _____ B. AM Snack <input type="checkbox"/> _____ to _____ C. Lunch <input type="checkbox"/> _____ to _____ D. PM Snack <input type="checkbox"/> _____ to _____ E. Dinner <input type="checkbox"/> _____ to _____ F. Eve Snack <input type="checkbox"/> _____ to _____	
11) Provider's number of own children under 4 years of age _____	14) Provider works outside home <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, hours of work: from _____ to _____ Name & phone # of work place: _____		17) <input type="checkbox"/> Licensed / Certified <input type="checkbox"/> Relative Care/Alternate Approval A. Expiration date _____ B. Capacity _____ C. Children under 2 _____ D. Own children _____ E. Non-Residential _____ Number of:
12) Is there a second or substitute caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, list name(s): _____	15) Relative Care Providers only: <i>I certify that <u>all outside children</u> for which I provide care are either siblings (including "step"), grandchildren (including "step" & "great"), Nieces/Nephews (including "step:"&"great") ONLY</i> Provider's Initials _____		16) Shift Care provided <input type="checkbox"/> Yes <input type="checkbox"/> No
13) Provider's language of choice: _____			
18) Have you ever been denied a state child care license or residential certificate <input type="checkbox"/> Yes <input type="checkbox"/> No When? _____			
19) Have you ever been terminated from the FDCH Program for cause? <input type="checkbox"/> Yes <input type="checkbox"/> No When? _____ Explain: _____			
20) Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White		21) Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
<i>(You may choose not to answer these questions and they will be filled out in the office to the best of the staff's ability)</i>			
I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; and that department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes. I certify that I am not currently enrolled under any other Sponsoring Organization of the Family Day Care Home Program. <i>I understand this application is good during the period listed in box number two (2) above.</i>			
Signature of provider: _____	Date _____	Signature of sponsor representative: _____	Date: _____

Provider Name:

Amendment to Application Meal Times	8) What hours care is provided: from _____ to _____	11) Meals claimed: A. Breakfast <input type="checkbox"/> _____ to _____ B. A.M. Snack <input type="checkbox"/> _____ to _____ C. Lunch <input type="checkbox"/> _____ to _____ D. P.M. Snack <input type="checkbox"/> _____ to _____ E. Dinner <input type="checkbox"/> _____ to _____ F. Eve. Snack <input type="checkbox"/> _____ to _____ (minimum of 2 hours between meal / snacks required)	Alternate meal times/days: (optional) Specify alternate days: _____ A. Breakfast <input type="checkbox"/> _____ to _____ B. A.M. Snack <input type="checkbox"/> _____ to _____ C. Lunch <input type="checkbox"/> _____ to _____ D. P.M. Snack <input type="checkbox"/> _____ to _____ E. Dinner <input type="checkbox"/> _____ to _____ F. Eve. Snack <input type="checkbox"/> _____ to _____	
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