FDCH APPLICATION FOR PARTICIPATION FOR FAMILY DAY CARE HOMES

Child and Adult Care Food Program ▪ Child Nutrition Programs ▪ USOE

Alliance for Children

APPROVAL TYPE: ☐ **LICENSE** ☐ **RESIDENTIAL CERTIFICATE** ☐ **RELATIVE CARE** ☐ **ALTERNATE CARE**

☐ **NEW** ☐ **TRANSFER** ☐ **CHANGE** ☐ **RENEWAL** ☐ **INACTIVE (date:________)**

TIER CLASSIFICATION: ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 2 Mixed**

(Office Use Only)

1) Provider's Identification Number_______________________

2) Renewal Effective Date (month) ___________ 20____ (enter month agreement was signed and current year; this application is good for one year from this date.)

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?

☐ Yes* ☐ No

*If **yes**, please answer the following:

Name of sponsor: ____________________

Date last claimed ____________________

Provider's language of choice:

Written__________________________

Spoken __________________________

5) Income eligible for Provider's own children (office use only): Yes ☐ No ☐

6) Tiering Determination – School, Census or Income (office use only)

A. ☐ **School**

District: ______________________

School______________________

Expiration date:______________________

B. ☐ **Census**

Block number:______________________

Expiration date:______________________

C. ☐ **Income**

Expiration date:______________________

7) Holiday care provided?

☐ Yes ☐ No *If yes*, check holidays care is offered below

☐Martin L. King Day
☐ President's Day
☐ Memorial Day
☐ Independence Day
☐ Labor Day

The following holidays are approved for reimbursement when providing care. Sign in/out sheet(s) required.

****New Years Day, Easter, Thanksgiving, & Christmas will not be reimbursed.**

8) Normal hours of care

from AM PM to AM PM

Alternate hours of care

Specify days______________

from AM PM to AM PM

9) Days of week day care is provided:

☐ Sunday ☐ Thursday
☐ Monday ☐ Friday
☐ Tuesday ☐ Saturday
☐ Wednesday

10) Meals claimed:

A. Breakfast	☐	_________	to	_________
B. AM Snack	☐	_________	to	_________
C. Lunch	☐	_________	to	_________
D. PM Snack	☐	_________	to	_________
E. Dinner	☐	_________	to	_________
F. Eve Snack	☐	_________	to	_________

Alternate meal times/days: (if applicable)

Specify alternate days/or if split shift:_____

A. Breakfast	☐	_________	to	_________
B. AM Snack	☐	_________	to	_________
C. Lunch	☐	_________	to	_________
D. PM Snack	☐	_________	to	_________
E. Dinner	☐	_________	to	_________
F. Eve Snack	☐	_________	to	_________

(A minimum of **2 hours** between the starting times of each meal/snack)

11) Is there a second or substitute caregiver?

☐ Yes ☐ No

If yes, list name(s):______________________

Phone(s): ______________________

(For Rel. Care or Alt Care providers please submit a BCI for all listed)

12) Provider works outside home ☐ Yes ☐ No

If yes, hours of work: from ________ to ________

Place of work:______________________

Work phone: ______________________

13) ☐ **Licensed / Certified**
☐ **Relative Care/Alternate Approval**

A. Expiration date ____________

B. Capacity ____________

Number of:

C. Children under 2 __________

D. Own children __________

E. Non-Resident day care __________

Number of provider's own children under 4 years of age: ________

14) Relative Care Providers only:

I certify that all outside children for which I provide care are either siblings (including "step"), grandchildren (including "step" & "great"), Nieces/Nephews (including "step:"&"great") ONLY **Provider's Initials** _______

15) Have you ever been denied a state child care license or residential certificate

☐ Yes ☐ No When? ___________ Explain:

16) Have you ever been terminated from the Food Program?

☐ Yes ☐ No When? __________ Explain:

17) Ethnicity:

☐ Hispanic
☐ Non-Hispanic

18) Race:

☐ American Indian or Alaskan Native ☐ Asian
☐ Black ☐ Pacific Islander ☐ White

Answering these questions is optional; however, the information is federally required for Alliance for Children
If you choose not to answer, Alliance for Children will complete to the best of their ability

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.

Signature of provider:	**Date**	**Signature of sponsor representative:**	**Date:**

This institution is an equal opportunity provider.

Provider Name:

FDCH Application Change Form

☐ **CHANGE** ☐ **REACTIVATE Effective Date**____________ ☐ **INACTIVE Effective Date**____________

Address____**City**__________________________**Zip**__________

TIER CLASSIFICATION: ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 2 Mixed**

Amendment to Application Meals

8) What hours care is provided:
from to

9) Days of week day care is provided:
☐ Sunday ☐ Thursday
☐ Monday ☐ Friday
☐ Tuesday ☐ Saturday
☐ Wednesday

11) **Meals claimed:**			**Alternate meal times/days/shifts:** (optional)		
A. Breakfast	☐ _________ to _________		A. Breakfast	☐ _________ to _________	
B. A.M. Snack	☐ _________ to _________		B. A.M. Snack	☐ _________ to _________	
C. Lunch	☐ _________ to _________		C. Lunch	☐ _________ to _________	
D. P.M. Snack	☐ _________ to _________		D. P.M. Snack	☐ _________ to _________	
E. Dinner	☐ _________ to _________		E. Dinner	☐ _________ to _________	
F. Eve. Snack	☐ _________ to _________		F. Eve. Snack	☐ _________ to _________	

(minimum of **2 hours** between meal / snacks required)

Specify alternate days:______________________

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C. Lunch	☐ _________ to _________		C. Lunch	☐ _________ to _________	
D. P.M. Snack	☐ _________ to _________		D. P.M. Snack	☐ _________ to _________	
E. Dinner	☐ _________ to _________		E. Dinner	☐ _________ to _________	
F. Eve. Snack	☐ _________ to _________		F. Eve. Snack	☐ _________ to _________	

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Provider Name:

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E. Dinner	☐	_________	to	_________
F. Eve. Snack	☐	_________	to	_________

(minimum of **2 hours** between meal / snacks required)

Alternate meal times/days/shifts: (optional)

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E. Dinner	☐	_________	to	_________
F. Eve. Snack	☐	_________	to	_________

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