FDCH APPLICATION FOR PARTICIPATION FOR FAMILY DAY CARE HOMES

Child and Adult Care Food Program • Child Nutrition Programs

APPROVAL TYPE: ☐ LICENSE ☐ FFN ☐ RESIDENTIAL CERTIFICATE ☐ RELATIVE CARE ☐ ALTERNATE CARE
☐ NEW ☐ TRANSFER ☐ CHANGE OF ADDRESS ☐ INACTIVE (date:________)

(Office Use Only)
Provider's Identification Number ______________

1) Provider Information: (PRINT CLEARLY)

Name: ____

Address: ________________________________ Apt #: ______

City: ________________________________ Zip:__________

Telephone Number: (_____)______________________

Cell Phone Number: (_____)______________________

Email Address: ________________________________

Date of Birth: __________________________________

2) 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 ________________________________

Have you ever been terminated from the Food Program?

☐ Yes ☐ No When? __________ Explain:

Provider's language of choice:
Written______________________________________

Spoken ______________________________________

3) Holiday care provided?
☐ Yes ☐ No *If yes*, check holidays care is offered below
☐Martin Luther King Jr. Day
☐ President's Day
☐ Memorial Day
☐ Independence Day
☐ Labor Day
The above holidays are approved for reimbursement when providing care..
****New Year's Day, Easter, Thanksgiving & Christmas will not be reimbursed.**

4) Normal hours of care:
from AM/PM to AM/PM

Alternate hours of care
Specify days____________
from AM/PM to AM/PM

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

6) Meals claimed:

Meal		From		To
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:_____

Meal		From		To
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)

7) For Licensed/Residential Certificate providers only:
Is there a second or substitute caregiver?
☐ Yes ☐ No
If yes, list name(s):________________________
Phone(s): ________________________

8) Provider works outside home ☐ Yes ☐ No
If yes, hours of work: from _____ to ______
Place of work: ________________________
Work phone: ________________________
Days working: ________________________

9) For Licensed / FFN / Certified providers only (as of the date of application):
A. Expiration date ___________
B. Capacity ___________

10) 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 _______

Relative Care and Alternate Approval Providers only:
I certify that I will complete a background check for all covered individuals in my household.

Provider's Initials _______

11) 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: ________

12) Have you ever been denied a state child care license, residential certificate or FFN approval?
☐ Yes ☐ No When? ___________ Explain:

13) Ethnicity:
☐ Hispanic
☐ Non-Hispanic

14) Race:
☐ American Indian or Alaskan Native ☐ Asian
☐ Black ☐ Pacific Islander ☐ White

Answering these questions is optional; however, the information is federally required for Sponsors
If you choose not to answer, the Sponsor completes 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 acknowledging receipt:	Date of Receipt: