



# CCDF Provider Eligibility Standards Packet

## NANNY CARE Recertification

## **IMPORTANT!!**

**No payment of CCDF voucher funds will be made to any provider or program until all CCDF Provider Eligibility Standards have been met and a visit verifying the compliance with the provider eligibility standards has occurred.**

A representative of The Consultants Consortium (TCC) will conduct a certification visit and information of compliance to the provider eligibility standards will be shared with the intake agent. Only then, can the provider/program receive funds from the CCDF voucher program. Payment will **not** be retroactive. Payment can begin only after the provider receives notification from the intake agent.

**A provider/program must be licensed, registered, or legally exempt from licensure to receive CCDF voucher dollars. *If care is being provided in the home, no more than 5 unrelated children can be in the care of the provider or the provider must be licensed. If you are unsure about the need for licensure in your site, call the Bureau of Child Care at 1-877-511-1144.***

### **\*\*\*\*\*Important\*\*\*\*\***

***Any felony criminal conviction or misdemeanor related to the health or safety of a child, the presence of an individual in the Sex Offender Registry or Child Protection Index will result in the permanent exclusion of the applicant from the CCDF Voucher Program. If any other individuals living or working at the child care location (husbands, wives, children, etc) have felony convictions or misdemeanors related to the health or safety of a child, the application will be denied.***

***Also, a positive drug test result from the provider or any other individual living or working at the child care location will temporarily result in the denial of the application.***

Please Keep This Information Sheet For Your Records.

**Provider Eligibility Standards Team  
Contact Information**

**Mailing Address:**

PO BOX 1186  
Indianapolis, IN 46206-1186

**Phone Number:** 1.317.638.7095

**Toll Free:** 1.866.921.6623

**Fax Number:** 1.317.972.0351

**Toll Free Fax:** 1.866.642.8002

**Email:** PES@e-tcc.com

Provider Packets are available online:

Visit: <http://www.in.gov/fssa/carefinder/>

**“Become A Certified Unlicensed CCDF Provider”**

Please Keep This Information Sheet For Your Records.

**\*\*\*\*\*IMPORTANT INFORMATION BELOW\*\*\*\*\***

**PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING ANY OF YOUR DOCUMENTATION**

- The parent must have 3 qualifying CCDF Voucher Children to be eligible for Nanny Care.
- Your application must be completed within 60 days. If the application is not completed within the 60 days we will return all file documentation and you will be required to submit a new application with updated documentation.
- A home inspection will not be scheduled until all file documentation is received in the office and approved by TCC including the background check results from the state.
- A copy of ALL documentation sent to TCC MUST be retained for your records. This will prevent any problems and possible additional costs to you if your paperwork is lost. You should request a copy of your drug test results from the lab conducting your test.
- Your Drug Test results are only valid for 60 days. A home inspection must be conducted and certification approval granted prior to the expiration date. If certification approval is not granted by the end of the 60 days you will be required to submit a new application including new/updated documentation.
- Your 53323 Consent to Release Information results are only valid for 60 days. A home inspection must be conducted and certification approval granted prior to the expiration date. If certification approval is not granted by the end of the 60 days you will be required to submit a new application including new/updated documentation.
- Children Immunization Records MUST BE on the form included in the packet.

# First Aid and CPR Requirements

## First Aid

The American Red Cross and National Safety Council classes are approved; however, they must include demonstration of skills. Therefore, online classes will not be accepted.

If another entity or individual is offering the course you must provide proof the course covered the following:

- ✓ Choking
- ✓ Bleeding
- ✓ Artificial Breathing
- ✓ Poisoning
- ✓ Seizures
- ✓ Shock

All courses must also require the pupil to complete a return demonstration of skills. These courses must be taught by a licensed R.N., L.P.N., M.D., D.O., E.M.T. Paramedic or a certified First Aid Instructor. The provider must submit proof of all of the above requirements to meet the CCDF Certification requirement. The instructors printed name and signature as well as whom they are certified through must be on the submitted documentation.

## CPR

The American Red Cross and National Safety Council classes taught by certified instructors are approved; however, they must include demonstration of skills. Therefore, online classes may not be accepted.

All other CPR courses must meet and document compliance with JAMA (Journal of American Medical Association) standards and be taught by a certified CPR instructor. The course should require that participants demonstrate skills on mannequins as well as pass a written or oral test. The submitted documentation must also have the instructors printed name and signature as well as whom they are certified through.

If you are obtaining instruction from the American Heart Association you must complete the certification process. Your card must state certification, not participation.

**PLEASE NOTE:** CPR training must be completed for all ages of children in your care. If you are caring for school-age children, it is necessary to obtain Adult CPR. In addition, CPR *must* be completed annually despite the expiration date on your CPR certification card.

*Please Keep This Information Sheet For Your Records.*  
**CHECKLIST FOR DOCUMENTATION TO BE SUBMITTED TO TCC**

**The parent/applicant is required to complete the following information.**

- \_\_\_\_\_ **Form A:** Application Request for CCDF Provider Eligibility Standards Certification
- \_\_\_\_\_ **Form B:** Household Members List
- \_\_\_\_\_ **Form B1:** Employees and Volunteer Caregivers List (if applicable)
- \_\_\_\_\_ Proof of running water- **Current** (within the previous 30 days) Water Bill or if you have Well Water or Spring Water then a Water Quality Test (within the last 12 months)
- \_\_\_\_\_ Proof of a landline phone – **Current** (within the previous 30 days) Phone Bill and the 2 months prior to the most current bill.

**The following is required for the provider, employees or volunteers and anyone living in the home over the age of 18 years.**

- \_\_\_\_\_ State Form 53323- Consent for Statewide Criminal History Check, Child Protection Index Check And Sex Offender Registry including any individual under the age of 18 previously waived to adult court.

**The following documentation is required for any NEW household members over 18; household members who have turned age 18 since your last certification, and any NEW staff/volunteer caregivers.**

- \_\_\_\_\_ Drug Test Results- The results must be provided to us directly from the lab along with the signed Drug Test Release Form. The Results must have a Medical Review Officers Signature
- \_\_\_\_\_ TB Test Results- Results must be signed by a physician or nurse practitioner
- \_\_\_\_\_ Picture ID- Preferably a State Driver's License or State ID – The ID must show the Date of Birth
- \_\_\_\_\_ Form C1- Supplemental Criminal History

**IMPORTANT NOTICE: THE RESULTS OF YOUR BACKGROUND CHECKS AND DRUG TEST RESULTS ARE ONLY VALID FOR 60 DAYS.** A site inspection must be conducted and certification approval granted prior to the expiration date. If certification approval is not granted by the end of the 60 days you will be required to submit a new application including new/updated documentation.

**Please return the above listed documentation to:**  
**The Consultants Consortium (TCC)**  
**PO BOX 1186**  
**Indianapolis, IN 46206-1186**

*Please Keep This Information Sheet For Your Records.*

**CHECKLIST FOR DOCUMENTATION TO BE SUBMITTED TO TCC**

**The Provider is required to complete the following information.**

- \_\_\_\_\_ Proof of your annual CPR Certification- We need a copy of the front and back of your card.  
(Online Classes are not accepted)
- \_\_\_\_\_ Proof of your current First Aid Training – We need a copy of the front and back of your card.  
(Online Classes are not accepted)
- \_\_\_\_\_ Child Care Information Sheet – Must be completed, signed and dated.
- \_\_\_\_\_ **Form 2:** Plan for Provider Illness

**The following is required for the provider, employees or volunteers and anyone living in the home over the age of 18 years.**

- \_\_\_\_\_ State Form 53323- Consent for Statewide Criminal History Check, Child Protection Index Check  
And Sex Offender Registry including any individual under the age of  
18 previously waived to adult court.
- \_\_\_\_\_ Picture ID- Preferably a State Driver’s License or State ID – The ID must show the Date of Birth

**IMPORTANT NOTICE: THE RESULTS OF YOUR BACKGROUND CHECKS AND DRUG TEST RESULTS ARE ONLY VALID FOR 60 DAYS. A site inspection must be conducted and certification approval granted prior to the expiration date. If certification approval is not granted by the end of the 60 days you will be required to submit a new application including new/updated documentation.**

**Please return the above listed documentation to:**

**The Consultants Consortium (TCC)  
PO BOX 1186  
Indianapolis, IN 46206-1186**

Please Keep This Information Sheet For Your Records.

**INSPECTION CHECKLIST-THESE ITEMS WILL BE VERIFIED BY TCC DURING THE HOME VISIT.**

**The following will be verified by a TCC representative during your home visit.**

- \_\_\_\_\_ **Form 1:** Evacuation plan in case of fire or severe weather –**MUST BE POSTED**
- \_\_\_\_\_ **Form 2:** Plan for Provider Illness- **MUST BE POSTED**
- \_\_\_\_\_ **Form 3:** Monthly Fire Drill Chart- **MUST BE POSTED**
- \_\_\_\_\_ **Form 4:** Emergency Telephone Numbers-**MUST BE POSTED**
- \_\_\_\_\_ **Form 5:** Emergency Contacts for Children
- \_\_\_\_\_ Child Immunization Records-**MUST BE ON THE ENCLOSED FORM & SIGNED BY THE CHILD'S DOCTOR/ MEDICAL PROFESSIONAL WITHIN THE LAST 12 MONTHS PRIOR TO YOUR INSPECTION.**
- \_\_\_\_\_ Working Landline Telephone
- \_\_\_\_\_ Working Smoke Detectors
- \_\_\_\_\_ Fire Extinguishers- Fire extinguishers are required on each floor of the home with an additional extinguisher in the kitchen area. Extinguishers **must be** 2 ½ pounds or greater and ABC Multiple-Purpose. **Single use Fire Extinguishers must be replaced every 24 months. They will be marked yearly at the time of your inspection.**
- \_\_\_\_\_ Verification all firearms and ammunition are inaccessible to children
- \_\_\_\_\_ Verification medications, poisons, chemicals, bleach, cleaning materials are inaccessible to children
- \_\_\_\_\_ Verification of Two Exits- The home must have 2 exits, other than windows, located on different sides of the home that are not blocked and do not require passage through a garage or storage area where hazardous materials (gas, cars, mowers etc) are stored and may be operated from the inside without the use of a key or any special knowledge.

**EMPLOYEE OR VOLUNTEERS (If applicable)** The following records will be verified by a TCC representative.

- \_\_\_\_\_ TB Test Results- Must be signed by a physician or Nurse Practitioner
- \_\_\_\_\_ Proof of Current First Aid Training (Online Classes are not accepted)
- \_\_\_\_\_ Proof of CPR Certification for at least one person at all times (Online classes are not accepted)
- \_\_\_\_\_ Drug Test Results- The Results must have a Medical Review Officers Signature and should be no more than 60 calendar days old based upon the hire date of the employee or volunteers.

**IMPORTANT NOTICE: THE RESULTS OF YOUR BACKGROUND CHECKS AND DRUG TEST RESULTS ARE ONLY VALID FOR 60 DAYS. A site inspection must be conducted and certification approval granted prior to the expiration date. If certification approval is not granted by the end of the 60 days you will be required to submit a new application including new/updated documentation.**

**TCC will request a Statewide Criminal History Check, Child Protection Index Check and Sex Offender Registry Check on the applicant, household members, employees and volunteers after submission of the completed State Form 53323. A home inspection will not be scheduled until the results of the checks have been received.**

# APPLICATION REQUEST FOR CCDF PROVIDER ELIGIBILITY STANDARDS CERTIFICATION

Parent: First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Provider: First Name \_\_\_\_\_ Last Name \_\_\_\_\_

County Name \_\_\_\_\_

Home/Site Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(if different from home address)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Landline Home Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ (required)

Cellular Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

(if applicable)

Additional Contact Number: ( \_\_\_\_\_ ) \_\_\_\_\_

(if applicable)

Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

Social Security Number (or) Employer Identification Number \_\_\_\_\_

Email Address (if applicable) \_\_\_\_\_

Day & Hours of Operation: \_\_\_\_\_

I understand that I will be visited by a representative of The Consultants Consortium (TCC). This visit will be scheduled after all required documentation is received by TCC. The verification visit will confirm compliance of the required CCDF Provider Eligibility Standards for receipt of CCDF childcare voucher dollars. If the provider eligibility standards are met with satisfaction, I will be certified by the Family and Social Service Administration as a certified CCDF childcare provider.

PARENT'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

*Please return **signed and dated** form to the verifying agency, TCC.*

**Form A**







Provider Name \_\_\_\_\_

### Emergency Contact Information to Be Posted By the Phone

Fire: 911 or (\_\_\_\_) \_\_\_\_\_

Ambulance: 911 or (\_\_\_\_) \_\_\_\_\_

Police: 911 or (\_\_\_\_) \_\_\_\_\_

Poison Control: 1-800-222-1222

Our address is:

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

Our Phone Number is: (\_\_\_\_) \_\_\_\_\_

If a child should need immediate medical assistance I will contact a rescue squad or hospital at 911 or (\_\_\_\_) \_\_\_\_\_. I will contact the parents of the injured or ill child to let them know their child's condition.

Transportation to the doctor or hospital will be provided by \_\_\_\_\_ (name the method of transportation to be used, such as personal car, rescue squad, taxi or neighbor's car)

*This form or one similar to it should be posted and will be verified by TCC during the Provider Eligibility Standards Certification visit.*

Form 4

Provider Name \_\_\_\_\_

## Emergency Contacts for Children

Child's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Birthdate \_\_\_\_\_

Primary Contact \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Beeper \_\_\_\_\_

Alternate Contact \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Beeper \_\_\_\_\_

Alternate Contact \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Beeper \_\_\_\_\_

Special medical health need(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

***This form or one similar to it and will be verified by TCC during the Provider Eligibility Standards Certification visit.***

**THIS IS A REQUIRED FORM**

Day Care Provider Name \_\_\_\_\_

**Child Immunization Record**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

***Record Date of Immunization***

	1	2	3	4	5
Hep B					
DtaP / DTP / Td					
Hib					
MMR					
IPV					
Varicella					
PCV / Prevnar					

Child has documented history of Varicella Disease \_\_\_\_ No \_\_\_\_ Yes If yes, age \_\_\_\_\_

**Please check the appropriate response.**

- Child has received complete age-appropriate immunizations.
- Child is currently in the process of receiving complete age-appropriate immunizations.

**ONE BOX ABOVE MUST BE CHECKED BY THE HEALTH CARE PROVIDER**

Comments: *(Please list immunizations excluded for medical reasons)*

\_\_\_\_\_  
\_\_\_\_\_

Parent comments: *(Please indicate religious objection, if any)*

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Health Care Provider's Signature and Date is **Required**.)

Printed Name and Title \_\_\_\_\_  
(Printed Name and Title is **Required**)

**This form must be updated annually.**

**DRUG TEST MUST BE CONDUCTED BY SAMSHA CERTIFIED LABS**  
**Child Care and Development Fund Drug Testing Guidelines**  
**Effective October 31, 2002**

Indiana Code 12-17.2-3.5-12.1 requires each childcare provider to provide drug test results which do not show a presence of illegal controlled substances for themselves, all individuals residing in the home over the age of eighteen (18) and any employee or individual caring for children on their behalf prior to participation in the Child Care and Development Fund (CCDF) program. This drug test shall test for Amphetamines, Cocaine, Opiates, PCP and THC. Each drug test shall meet the following criteria.

1. Chain of Custody shall follow guidelines, which are consistent with U.S. Department of Transportation requirements. (See specific Chain of Custody instructions listed below.)
2. Each drug screen shall be processed by a lab, which has been certified by the Substance Abuse and Mental Health Services Administration (SAMHSA, formerly NIDA).
3. Drug test results shall be reviewed by a nationally certified Medical Review Officer using positive cut-offs established by the U.S. Department of Transportation. Drug test results must include contact information for the Medical Review Officer and signature when possible.
4. Drug test results shall be faxed or mailed to the verifying agent.

The following Chain of Custody shall be followed for drug testing results provided to the Family and Social Services Administration as required by Indiana Code.

- The collector shall ask the donor for photo identification.
- After verification of donor's identification, the collector will complete step one of the custody of control form provided by the laboratory (non-regulated).
- The collector will ask the donor to remove any unnecessary outer clothing (coat, etc.) and leave hand carried items (briefcase, etc.) outside toilet enclosure. The donor may be required to empty his/her pockets at collector's discretion.
- The collector will instruct the donor to wash and dry his/her hands.
- The collector will provide the donor a wrapped and sealed collection container and/or specimen bottle. Either the collector or the donor may open the container bottles in donor's presence.
- If the container and bottle are wrapped together, the donor should be allowed to take container and bottle into toilet enclosure. If container and bottle are wrapped separately, only the collection container should be taken into toilet enclosure. The wrapped bottle should remain outside enclosure and then opened in the donor's presence when the donor gives the filled collection container to the collector.
- The collector will accompany the donor to toilet enclosure when it is time for the donor to provide urine sample. The donor will enter toilet enclosure and shut the door, the collector remains outside the closed door.
- The donor will hand filled collection container to the collector, both the donor and the collector should maintain visual contact of the specimen until labels and seals are placed over bottle caps.
- The collector checks specimen and reading of the specimen temperature indicator within four minutes of receiving the specimen from the donor. The collector then marks the appropriate box on custody of control form.
- The collector checks specimen volume ensuring there is at least thirty milliliters of urine in a single specimen collection.
- The collector checks specimen for unusual color, odor or other physical qualities that may indicate an attempt to adulterate the specimen.
- The collector will pour at least thirty milliliters into the specimen bottle.
- The collector immediately places lid/caps on specimen bottle and then applies tamper evident labels/seals.
- The collector will write the date on label field. The donor will be asked to initial labels/seals when affixed to the bottles.
- After sealing the specimen bottle, the donor will be permitted to wash and dry his/her hands, if he/she so desires.
- The donor will be instructed to read and complete the donor certification section of the custody of control form, including signing certification statement.
- The collector will complete collector's certification section of custody of control form, including signing certification statement.
- The collector will record any remarks concerning collection process in "remarks section" of custody of control form.
- The collector will complete chain of custody block of custody of control form. At a minimum, the collector will complete; the specimen, received by, purpose of, change, date, and released by blocks of the custody of control form.
- The collector will give the donor his/her copy of custody of control form and the donor may leave collection site at completion of this step of the collection process. It is not necessary for the donor to remain at collection sight while specimen bottle and custody of control form are prepared and packaged for shipment.
- The collector will prepare the bottle and copies of the custody of control form for shipment to the laboratory. The bottles and custody of control form copies will be shipped in a padded mailer or shipping container secured with an outer seal. The collector will initial and date the seal on the shipping container.
- Finally, the collector will send the MRO copy of the form directly to the MRO addressed on the form and the employer copy to the designated representative.

## CCDF Substance Abuse Screening Test Consent Form

CCDF Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_

CCDF Provider Address: \_\_\_\_\_

- Provider
- Employee
- Household Member

Individual providing sample: \_\_\_\_\_

Indiana Code 12-17.2-3.5-12.1 requires that each childcare provider shall provide drug test results which do not show a presence of illegal controlled substance(s) for themselves, all individuals residing in the home over the age of eighteen (18) and any employee or volunteer caregivers caring for children prior to participation in the Child Care and Development Fund (CCDF) program. This shall include Amphetamines, Cocaine, Opiates, PCP and THC.

I, the undersigned, have been informed that drug test results must be provided to the Division of Family Resources (DFR) and the CCDF verifying entity for participation in the CCDF program. The DFR and the verifying agency shall maintain confidentiality of these results. The results of this drug test will be used to determine eligibility for participation in the CCDF program. If drug testing results of the provider or any individual required to supply such a test, indicate the presence of an illegal controlled substance, the provider is ineligible to participate in the CCDF program. I further understand that this test and any subsequent test will be conducted at the provider's expense. An inconclusive drug test will not be considered a drug test for purposes of determining program eligibility.

Name of Verifying Agency: **The Consultants Consortium (TCC)**

Name of Contact Person: **Christy Christianson, PES Program Manager** Fax Number: **317-972-0351 or 866-642-8002**

Address: **PO Box 1186, Indianapolis, IN 46206-1186** Phone Number: **317-638-7095 or 866-921-6623**

I understand that if I refuse to consent to take the test and provide the results to the DFR and the verifying agency, the verifying entity will be unable to document my compliance with CCDF Provider Eligibility Standards and thereby will be unable to authorize me, my household member's or employer's participation in the CCDF program. *I understand that I may be required to provide additional test on a random basis or when suspicion of non-compliance is documented.*

I have read and understand the Drug Testing Guidelines and consent form that have been provided to me.

I hereby: \_\_\_\_\_ Consent \_\_\_\_\_ Refuse to Consent

to the drug test; to providing the results to the DFR and the verifying agency, and to the use of the results to determine eligibility for the CCDF voucher program.

Individual receiving test: \_\_\_\_\_ Date/Time \_\_\_\_\_

Collection Site Representative: \_\_\_\_\_ Date/Time \_\_\_\_\_

***(Please provide a copy of this signed release form with the drug test results to the agency listed above.)***



**CONSENT TO RELEASE INFORMATION FOR LICENSED CENTERS,  
LICENSED HOMES, UNLICENSED REGISTERED MINISTRIES, AND CCDF LLEPs**

State Form 53323 (R3 / 8-11)

DIVISION OF FAMILY RESOURCES / BUREAU OF CHILD CARE

The information in this document is confidential according to IC 6.1-1-35-9.

In accordance with IC 12-17.2-4-5(a)(1), IC 12-17.2-4-32(a), and IC 12-17.2-6-14(c), each staff member and/or volunteer shall complete a section of this form in order to have their background information checked.

You must return this completed form to your consultant.

Name of facility / licensee / LLEP / applicant		
Address of facility (number and street, city, state, and ZIP code)		
License / registration number / LLEP number	Name of consultant	County

By signing below, I hereby consent to a release of information from Child Protective Services and the Criminal Justice System to the Indiana Child Care Licensing Section, Bureau of Child Care, and to the licensee / applicant. The information may contain any prior criminal history, arrest record, or child protective service history and is sought to ensure the safety of children in child care settings. I also verify that all information given here is correct.

Name (please print)		Maiden or other name	
Type <input type="checkbox"/> Applicant <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Household member (should be over eighteen (18) years old)			
Social Security number	Date of birth (month, day, year)	Sex	Race
Address (number and street, city, state, and ZIP code)			
Signature		Date (month, day, year)	

<b>FOR OFFICE USE ONLY</b>	CH <input type="checkbox"/> Record found	Date (month, day, year)	CPI <input type="checkbox"/> Record found	Date (month, day, year)	SOR <input type="checkbox"/> Record found	Date (month, day, year)
	<input type="checkbox"/> Record not found		<input type="checkbox"/> Record not found		<input type="checkbox"/> Record not found	

Name (please print)		Maiden or other name	
Type <input type="checkbox"/> Applicant <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Household member (should be over eighteen (18) years old)			
Social Security number	Date of birth (month, day, year)	Sex	Race
Address (number and street, city, state, and ZIP code)			
Signature		Date (month, day, year)	

<b>FOR OFFICE USE ONLY</b>	CH <input type="checkbox"/> Record found	Date (month, day, year)	CPI <input type="checkbox"/> Record found	Date (month, day, year)	SOR <input type="checkbox"/> Record found	Date (month, day, year)
	<input type="checkbox"/> Record not found		<input type="checkbox"/> Record not found		<input type="checkbox"/> Record not found	

Name (please print)		Maiden or other name	
Type <input type="checkbox"/> Applicant <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Household member (should be over eighteen (18) years old)			
Social Security number	Date of birth (month, day, year)	Sex	Race
Address (number and street, city, state, and ZIP code)			
Signature		Date (month, day, year)	

<b>FOR OFFICE USE ONLY</b>	CH <input type="checkbox"/> Record found	Date (month, day, year)	CPI <input type="checkbox"/> Record found	Date (month, day, year)	SOR <input type="checkbox"/> Record found	Date (month, day, year)
	<input type="checkbox"/> Record not found		<input type="checkbox"/> Record not found		<input type="checkbox"/> Record not found	

<b>FOR BCC STAFF ONLY</b>	Signature of Bureau of Child Care staff verifying information	Date (month, day, year)
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## Child Care Information Sheet

*List all children under 12 being cared for in this home, including the provider's (nanny's) children, if applicable.*

Provider Name \_\_\_\_\_

Child's Name	Child's Date of Birth	Own Child	Relative	How is this child related to you? (grandchild, niece, nephew, step-aunt or step-nephew)	Child Care Child
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

- The children listed above are the children I provide child care for (CCDF Voucher Children and non-CCDF Voucher Children) and my own children that are under the age of 7.

I am not caring for any children this time.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (Your signature is required even if you do not have any children in your care.)

Provider Name \_\_\_\_\_

## Plan for Provider Illness

Written plan in case of provider illness, injury, or death

**Please make sure you fill out this form completely and sign and date the form at the bottom.**

- ❖ If I should get seriously injured or become seriously ill or expire, I/emergency personnel will call \_\_\_\_\_ at (\_\_\_\_\_) \_\_\_\_\_ who will notify the parents to come and pick up their children immediately. The person named above will not care for the children, but only stay long enough for the parents to arrive.  
(Name of Contact Person) (Area Code and Phone Number)
- ❖ The children's records are located \_\_\_\_\_.
- ❖ I have provided each parent with the phone number of the childcare resource and referral agency to assist in finding emergency care. The number is **1-800-299-1627**.
- ❖ If I should get hurt or become ill and I am able to, I will notify the parents or guardians of the children to come and pick them up or I will provide a qualified substitute caregiver.

**Are you going to use a substitute caregiver? (Please select one) YES or NO**

**IF USING A SUBSTITUTE CAREGIVER**, please provide the name: \_\_\_\_\_  
I understand this individual must meet all requirements: drug test, TB Test, CPR and First AID Training and signed release for Child Abuse, Sex Offender Registry as well as Criminal History Checks.

- ❖ If I care for a child who is capable of understanding what to do in an emergency situation I will teach him or her how to contact another adult and/or call 911.

**I understand by my signature I agree that the above plans will be followed in case of my illness and a copy of this will be posted in my home at all times.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

***This form or one similar to it, must be posted in your home in a visible location.  
You must also submit it to the verifying agency, TCC.***

Provider Name \_\_\_\_\_

**Supplemental Criminal History Information**  
**Child Care Development Fund**  
**Household Member, Employee or Volunteer**

I, \_\_\_\_\_, have been informed that participation in the Child Care Development Fund  
**(Household Member, Employee or Volunteer)**

Voucher Program requires the following individuals to consent to a statewide criminal history check:

- a. The provider (defined as the applicant for voucher payment)
- b. If the provider provides child care in the provider's home, any individual who resides with the provider and who is:
  1. at least 18 years of age; or
  2. less than 18 years of age but has previously been waived from juvenile court to adult count; and
- c. Any employee or volunteer serving as a caregiver at the facility where the provider provides child care.

I have also been informed that in addition to the requirement to consent to a statewide criminal history check, I shall report to the verifying agency, The Consultants Consortium, any information regarding:

1. Police investigations;
2. Arrests; and
3. Criminal convictions

not listed on a the criminal history provided regarding any of the persons required to provide the criminal history listed above.

**I understand by my signature that I must report this information to the child care provider requesting my criminal history immediately and that my failure to report this information may result in the provider's inability to participate in the Child Care Development Fund Voucher Program.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please return **signed and dated** form to the verifying agency, TCC.*