



CCDF Provider Eligibility Standards Packet Facility Recertification

IMPORTANT!!

To continue participation as a provider for the CCDF voucher program, the facility must demonstrate it is still in compliance with CCDF Provider Eligibility Standards. A verifying visit must occur within 12 months of the previous certification visit to avoid a disruption in participation.

No payment of CCDF voucher funds will be made to any program until all provider standards have been met and a visit verifying compliance 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. Failure to complete re-certification will result in your inability to continue as a CCDF voucher provider.

*******Important*******

If, during the recertification process, TCC discovers that the facility was previously certified with documentation that does not meet the state's CCDF Provider Eligibility Standards, you will be required to submit new documentation. (For example, if the drug testing was not performed by a drug testing laboratory that meets CCDF Provider Eligibility Standards Guidelines.)

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”

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, it must cover 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/or 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 will 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.

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

- _____ Form A: Application Request for CCDF Provider Eligibility Standards Certification
- _____ Form B: Caregivers/Volunteer Caregivers Worksheet
- _____ Written Supervision Policy for employees under the age of 18, if applicable.
- _____ Written Emergency Staffing Plan
- _____ Proof of running water- **Current** Water Bill or if you have Well Water or Spring Water then a Water Quality Test (within the last 12 months) (**PUBLIC SCHOOLS EXEMPT**)
- _____ Proof of continuous phone service- current (previous 30 days) phone bill and the 2 months prior to your most current phone bill (**PUBLIC SCHOOLS EXEMPT**)

Additionally, the individual completing this application should include the following documentation:

- _____ State Form 53323- Consent for Statewide Criminal History Check, Child Protection Index Check And Sex Offender Registry
- _____ Picture ID- Preferably a State Driver's License or State ID – The ID must show the Date of Birth
- _____ Proof of Current First Aid and Annual CPR (**Online Classes are not accepted**)
- _____ Annual Screening Results for any person/s with a positive TB result in the past.

The following is required for the employees or volunteers.

- _____ Picture ID- Preferably a State Driver's License or State ID – The ID must show the Date of Birth
- _____ 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.

****IMPORTANT INFORMATION****The criminal history check that is completed on the State Form 53323 can only be completed for individuals 18 or older or individuals previously waived to adult court. If you have employees under the age of 18 please read and follow the **Juvenile Criminal History** instructions and form included in this packet.

A site 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.

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.

PLEASE RETURN THE ABOVE LISTED OFFICE 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 SITE VISIT.

- _____ Child Immunization Records will be reviewed. They are **REQUIRED** to be on the state form included in this packet.
- _____ **FORM 1-** Posted evacuation plan in case of fire or severe weather
- _____ **Form 3 -** Posted monthly fire drill chart
- _____ **Form 4-** Posted emergency telephone numbers
- _____ **Form 5-** Emergency contact information for all children
- _____ Verification of a working landline telephone
- _____ Fire Marshall Compliance Letter – PUBLIC SCHOOL EXEMPT
- _____ Verification all firearms and ammunition inaccessible to children
- _____ Verification all medications, poisons, chemicals, bleach, cleaning materials are inaccessible to children
- _____ Verification of two exits- The facility must have 2 exits, other than windows, located on different sides of the facility 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/volunteer records to be verified by a representative from TCC

- _____ Results of TB tests, signed by a physician or nurse practitioner – original
- _____ Proof of current First Aid training (Online Classes are not accepted)
- _____ Proof of CPR 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.
- _____ **Form C1-**Supplemental Criminal History

A SITE 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.

APPLICATION REQUEST FOR CCDF PROVIDER ELIGIBILITY STANDARDS CERTIFICATION

Legal Business Name: _____

DBA: _____

Facility Directors: First Name _____ Last Name _____

Additional Contact Names (if applicable):

First Name _____ Last Name _____

First Name _____ Last Name _____

County Name _____

Site Address: _____

City _____ State _____ Zip Code _____

Mailing Address: _____

(if different from site address)

City _____ State _____ Zip Code _____

Site Telephone Number: (_____) _____

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.

PROVIDER SIGNATURE _____ **Date** _____

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

Form A

PES Facility Recertification Packet
Revised 06.2011

Caregivers/Volunteer Caregivers Worksheet

Facility Director (Applicant) _____ Business Name _____

Please list all individuals who will be providing care and whose documentation will be verified by The Consultants Consortium (TCC) at the time of certification. Please attach **copies** of identification (i.e. driver license) of all individuals who will be providing care.

Printed Staff Name	INTERNAL USE	Birth Date	Current Age
Facility Directors Name:			
Staff:			
Staff:			
Staff:			
Staff:			
Staff:			
Staff:			
Staff:			

I certify that the individuals listed above are the only persons serving as caregivers or volunteer caregivers at this location. I understand that should staffing changes take place after certification; the appropriate personal documentation will be collected and made available to the TCC upon request. Failure to stay in compliance with staffing documentation requirements will be considered non-compliance and could result in the inability of your organization to participate in the CCDF Provider Eligibility Standards program.

Applicant's signature _____ Date _____

Title _____

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

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)	

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

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

FOR OFFICE USE ONLY	CH <input type="checkbox"/> Record found <input type="checkbox"/> Record not found	Date (month, day, year)	CPI <input type="checkbox"/> Record found <input type="checkbox"/> Record not found	Date (month, day, year)	SOR <input type="checkbox"/> Record found <input type="checkbox"/> Record not found	Date (month, day, year)
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FOR BCC STAFF ONLY	Signature of Bureau of Child Care staff verifying information	Date (month, day, year)
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Juvenile Criminal History

-The juvenile along with a parent or guardian must go to a local law enforcement agency (**NOT** a State Police Post) and ask for fingerprints to be done on a card for a Juvenile Review Challenge. They do not go to an L-1 site because they only do National Criminal History Checks. The local agency may or may not charge a fee for the fingerprints. This would be separate from the \$10 charge by the State Police.

-**DO NOT** leave the card with the local law enforcement agency or ask them to run the check.

- The attached form, fingerprint card, and a \$10 certified check or money order payable to the State Of Indiana must be sent together to the address on the form.

-If there are questions about the Review Challenges they can contact Kathi Mauritzen at 317-232-8266.

-You will need to obtain a copy of the completed form and money order from the parent and submit it to the PES Department for your file.

-The criminal history results will be returned to the parent and a copy of the results must then be submitted to the PES Department within 60 days of the request.

(Please type or print all information)

NAME OF JUVENILE

Last Name

First Name

M.I.

Date of Birth

Sex

Race

Juvenile's Residence Address

REQUEST FOR JUVENILE CRIMINAL HISTORY INFORMATION

Indiana Code 31-39-1-2: "All juvenile court records are confidential."

In accordance with Indiana Code 5-2-5.1-13, juvenile criminal history data may only be released to that individual, their parent, guardian, or custodian.

Juvenile criminal history data may be obtained two (2) ways:

- 1) The subject of the request; their parent, legal guardian, or custodian may come into our office (address below) and request the criminal history information in person.
 - a) Must have picture I.D., or Social Security card & Birth Certificate of the juvenile.
 - b) The requestor must be the subject of the request, their parent, guardian, or custodian.
 - c) This form- *no exceptions*
 - d) \$10.00 cash, certified check, or money order payable to STATE OF INDIANA
(No Personal Checks)
- 2) Request by mail-please submit the following:
 - a) This form- *no exceptions*
 - b) A complete set of fingerprints taken by a law enforcement agency
 - c) \$10.00 cash, certified check, or money order payable to STATE OF INDIANA
(No Personal Checks)

WARNING-PENALTY FOR MISUSE

The individual receiving the response for juvenile criminal history information may not utilize it for purposes other than those stated in the Indiana Code, or for purposes which deny the subject of this request any civil right to which he or she is entitled.

Any person who uses the response to this request for juvenile criminal history information for any purpose prohibited by law commits a Class A misdemeanor offense under IC 5-2-25-5, and maybe sentenced up to one year in jail.

I affirm, under the penalty of perjury, that the information I have provided on this form is true, and the response to this request for Juvenile Criminal history information will not be used in violation of law.

Signature of Requestor

Date

Cash will be accepted only if request is in person; otherwise, *certified checks* and *money orders* should be payable to STATE OF INDIANA.

Mail request to:
Indiana State Police, Central Repository
P.O. Box 6188
Indianapolis, IN 46206-6188

Provider Name _____

Supplemental Criminal History Information
Child Care Development Fund
Director

I, _____, have been informed that participation in the Child Care Development Fund Voucher

(Directors Name)

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

- a. The provider (defined as the applicant for voucher payment)
- b. 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 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 verifying agency immediately and that my failure to report this information may result in my inability to participate in the Child Care Development Fund Voucher Program.

Signed, _____ Date

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

Form C

Provider Name _____

Supplemental Criminal History Information
Child Care Development Fund
Employee or Volunteer

I, _____, have been informed that participation in the Child Care Development Fund Voucher

(Employee or Volunteer Name)

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

- a. The provider (defined as the applicant for voucher payment)
- b. 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 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.

Signed, _____ Date _____

This form must be signed and maintained by the facility.

Form C-1

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 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 will be verified by TCC during the Provider
Eligibility Standards Certification visit.***

Form 5

Provider Name _____

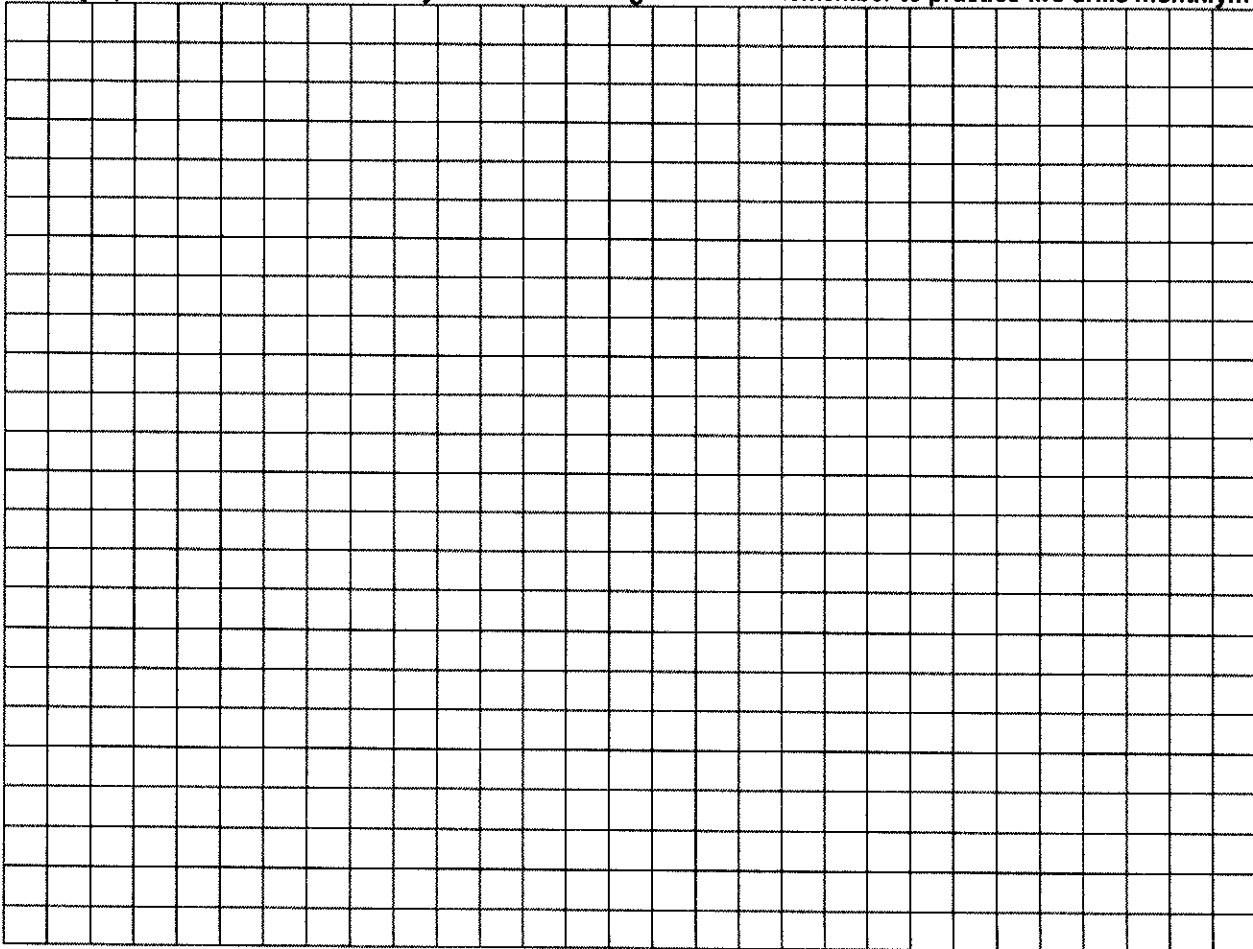
Location Address _____

Evacuation Plan In Case of a Fire or Other Emergency

Use the graph below to draw a floor plan layout of your home.

- ❖ Label each room in your home
- ❖ Mark the doors in your home
- ❖ Use arrows to show **two ways out.**
- ❖ Mark the **Severe Weather Location**- Mark the location on the graph above where you will gather in the event of a tornado or severe weather. **It should be a basement or interior area**, where the children will not be exposed to flying glass. If possible, store a battery operated radio and flashlight, blankets, small toys and books in this area. Take your cell or portable phone (if available) with you to this area.

This graph should reflect the route you will take during a fire drill. Remember to practice fire drills monthly!!!



*Fire Extinguishers are required on each floor of the home with an additional extinguisher in the kitchen.

Please indicate an outside meeting place: _____
This location should be at least 50 ft from your home.

Severe Weather Plan Location: _____

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

Form 1

