Unregulated Child Care Provider Enrollment

Thank you for your interest in becoming a DCF child care provider for families who may be eligible for DCF Child Care Assistance. This enrollment is used for child care providers who are not regulated by the Kansas Department of Health and Environment (KDHE). DCF must take certain steps in order to ensure the health and safety of children in your care who are funded through the child care assistance program. Prior to completing the enrollment, read and make sure you understand the DCF Child Care Provider Handbook.

Please return completed enrollment to: __________________________________________

________________________________________

________________________________________

Please return by: __________________________________________

Please note:

- If you are exempt from KDHE licensing, you must attach verification of KDHE Exempt Status. If your program site is not located at a school attendance center, Fire Inspection Documentation is required.

- All other Unregulated Provider types must attach Standards set by sponsoring state or agency.

DCF UNREGULATED CHILD CARE PROVIDER APPLICATION

Section 1:

Facility Information:

Name of Facility: __________________________ Director: __________________________

Street Address: __________________________ City: __________________________
County: _____________________  State: ______________________  Zip: _______________________

Mailing Address: _____________________________________  City: __________________________

County: _____________________  State: ______________________  Zip: _______________________

Primary Telephone Number: ____________________  Alternate Telephone Number: ______________

Email Address: __________________________________________

Are you exempt from licensing? ________________________  If licensed by another state or agency,

License number: ___________________________  Date of license: ____________________________

Headquarters (Complete this information only if you have more than one facility that is enrolled or

enrolling with DCF):

Name: ____________________________________________________________________________

Address: __________________________________________________________________________

Telephone Number: _________________________  Fax Number: _______________________________

Email Address: __________________________________________

**Owner Information:**

Name (first, middle, last): _____________________________________________________________

Street Address: _____________________________________  City: ____________________________

County: _____________________  State: ______________________  Zip: _______________________

Mailing Address: _____________________________________  City: ____________________________

County: _____________________  State: ______________________  Zip: _______________________

Primary Telephone Number: ____________________  Alternate Telephone Number: ______________

SSN/EIN: ___________________________  Date of Birth: __________________________ Gender: ____

Race: ____________________________  Hispanic/Latino? __________________________

Are you a high school graduate or do you have a GED? ___________________

Primary Language Spoken: ___________________________  Written: __________________________

C-13
Page 2
Rate Information:

If you are a Licensed Day Care Home, how much do you charge?

Under 18 months: ______________________ Frequency: _________________________________

18 months and over: ______________________ Frequency: _________________________________

If you are a Child Care Center, how much do you charge?

Under 12 months: ______________________ Frequency: _________________________________

13 months to 18 months: ______________________ Frequency: _________________________________

19 months to 30 months: ______________________ Frequency: _________________________________

31 months to 5 years: ______________________ Frequency: _________________________________

6 years and over: ______________________ Frequency: _________________________________

Do you charge an enrollment fee? _______ If so what is your fee? $_______/child $_______/family

Do you charge for a minimum daily rate? _______ If so, what is your minimum daily rate? _______

Do you charge for a minimum number of hours per day? _______ If so, how many hours do you charge for? ________________

List days and hours of operation:

Monday – Friday: ________ AM/PM to ________ AM/PM

Saturday: ________ AM/PM to ________ AM/PM

Sunday: ________ AM/PM to ________ AM/PM
**Background Check:** Background checks are completed on all providers enrolling with DCF. DCF checks the name(s) of the provider and all persons age 10 or over who reside, work or regularly volunteer in a child care facility. Each person must pass a background check before the agreement is approved. A provider is not eligible to be approved if the names of any of these persons appear on the Child Abuse-Neglect Registry, the Adult Abuse, Neglect or Exploitation Registry or the Kansas Adult Supervised Population Electronic Repository (KASPER), or if any of them have felony convictions.

Please list all persons age 10 or over who reside, work or regularly volunteer in the child care facility, including the Owner and Substitutes. Attach an extra sheet if necessary. (Changes must be reported to child care provider enrollment staff.)

<table>
<thead>
<tr>
<th>Role</th>
<th>Effective Date of Affiliation</th>
<th>Name (Last, First, Middle)</th>
<th>Maiden Name or Other Aliases</th>
<th>SSN</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Race</th>
<th>Hispanic/Latino (Y or N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has anyone who lives, works or volunteers regularly in your facility/home been convicted of a felony?

____________________________________________________________________________________

If Yes, provide Name of Person, Date and Court of Action, County and State:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Read the following statements and check if you agree:

_____ I/We declare, under penalty of perjury, that to the best of my (our) knowledge, the information provided in this application is true and correct.

_____ I understand that the terms listed in the DCF provider handbook and child care provider agreement (including Section 9) are incorporated into my provider agreement with DCF and are legally binding. My signature on this application certifies that I have read and understand those terms and agree to them.

_____ I/We the undersigned are the person(s) named as the Applicant or the person(s) authorized to represent the owner listed above.

Print Provider Name  ________________________________  Print EES Designee Name  ________________________________

Provider Signature and Date  ________________________________  EES Designee Signature and Date  ________________________________

Submit this completed form along with the following documents:

- a signed Policy Statement on Discipline (form in handbook)
- verification of KDHE exempt status (if exempt)
- a copy of your license (if licensed by another state or agency)
- standards set by sponsoring state or agency (if licensed by another state or agency)
- Fire Inspection documentation (if not located at a school attendance center)

FOR AGENCY USE ONLY:

Agreement Start Date: ________________________________  End Date: ________________________________

County Code: ________________________________  Provider ID: ________________________________