In-Home Relative 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. As an in-home provider, you are not regulated by the Kansas Department of Health and Environment. DCF must take certain steps in order to ensure health and safety of the children in your care who are funded through the Child Care Assistance Program. Prior to completing this enrollment, read and make sure you understand the DCF Child Care Provider Handbook.

Please return completed enrollment to: ____

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Please return by: ____

Note: As an In-Home child care provider, you are enrolling to provide care for the children in one specific family. To provide care for any other children would require a separate enrollment.

DCF IN-HOME RELATIVE CHILD CARE PROVIDER APPLICATION

Section 1:

Provider Information:

Name (first, middle, last): ____

Maiden Name: _________________________________ Alias: ____________________________________

SSN: ___________________________ Date of Birth: _________________________ Gender: _________

Race: __________________________________ Hispanic/Latino? ________________________________

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

Primary Language Spoken: ____________________________ Written: ____________________________

Street Address: ____________________________________ City: _________________________________

County: ______________________ State: _______________________ Zip: ________________________

Mailing Address: ____________________________________ City: ________________________________

County: ______________________ State: _______________________ Zip: ________________________

Primary Telephone Number: ___________________ Alternate Telephone Number: ________________

Email Address: ____

Have you been convicted of a felony? _________ If yes, provide date and court of action, county and state: ____

Parent of children for whom you will be caring:

Name (first, middle, last): ____

Social Security Number: ________________________Employer ID Number (EIN): ___________________

Primary Telephone Number: ___________________ Alternate Telephone Number: ________________

Street Address: ____________________________________ City: _________________________________

County: ______________________ State: _______________________ Zip: ________________________

Mailing Address: ____________________________________ City: ________________________________

County: ______________________ State: _______________________ Zip: ________________________

Primary Language Spoken: ____________________________ Written: ___________________________

Children for whom you will be caring:

In the last column please explain how each child is related to YOU.

Child Name	Date Care Began	Times of Care	Relationship

Background Check: Background checks are completed on all providers enrolling with DCF. DCF checks the name of the in-home provider, and the name must be cleared before approval for payment begins.

A provider is not eligible to be approved if his or her name appears in the Child Abuse-Neglect Registry, the Adult Abuse, Neglect or Exploitation Registry or the Kansas Adult Supervised Population Electronic Repository (KASPER), or if he or she has felony convictions.

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 EES Designee Name

____ ____

Provider Signature and Date EES Designee Signature and Date

Submit this completed form along with verification of the parent's employer ID number (EIN), a signed Policy Statement on Discipline and a signed (by both parent and provider) Health and Safety Standards – Home Checklist (forms in handbook).

FOR AGENCY USE ONLY:

Agreement Start Date: ________________________ End Date: ________________________

County Code: ________________________ Provider ID: ________________________