



Licensed Child Care Provider Application

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 KDHE licensed providers. Prior to completing the enrollment application, read and make sure you understand the DCF Child Care Provider Handbook.

Please return completed application to: _____

Please return by: _____

DCF LICENSED CHILD CARE PROVIDER APPLICATION Section 1:

Facility Information:

Name of Facility: _____ Director: _____

Facility License Number: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____

County: _____ State: _____ Zip: _____

Primary Telephone Number: _____ Alternate Telephone Number: _____

Email Address: _____

Can this email address be used to make contact? Yes No

Owner Information:

Name (first, middle, last): _____

Street Address: _____ City: _____

County: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____

County: _____ State: _____ Zip: _____

Telephone Number: _____ Fax: _____ Email: _____

SSN _____ Federal Employer ID Number _____
(required for tax purposes)

Race: _____ Hispanic/Latino? _____

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

Primary Language Spoken: _____ Written: _____

Headquarters (Complete this information only if you have more than one facility that is enrolled or enrolling with DCF and is considered a headquarters)

Name: _____

Mailing Address: _____ City: _____

Telephone Number: _____ Fax: _____

Email: _____

Can this email address be used to make contact? Yes No

LICENSED CHILD CARE CENTER RATES:

AGE	AMOUNT	FREQUENCY
Infant 0-11 months		
Toddler 12-35 months		
Preschool 36-59 months		
School Age 60 months and older		

LICENSED CHILD CARE HOME RATES:

AGE	AMOUNT	FREQUENCY
Infants 0-17 months		
Toddler 18-35 months		
Preschool 36-59 months		
School Age 60 months and older		

Do you charge an Enrollment fee? _____
Enrollment fee/child: _____
Enrollment fee/family: _____

Do you charge a minimum daily rate? _____
If yes, your minimum daily rate: _____

Do you charge a minimum number of hours/days? _____
If Yes, your minimum number of hours: _____

FACILITY OPERATION INFORMATION

_____ All Year (Jan through Dec) _____ Summer Only (June through Aug)

_____ School Year Only (Sept through May)

DAYS AND HOURS OF OPERATION

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Does anyone who lives, works, or volunteers in your home/facility have felony convictions that have not been expunged?

YES NO EXPUNGED

If yes, provide name of person, date and court of action, county and state: _____

Please go to the next page for statement review and signature

Read the following statements and check that 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.

DCF Provider Permission to Release Information and Signature

My signature on this application authorizes employers, health care providers, EBT Contractor, and other financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to Kansas Department for Children and Families (DCF) any information, including, banking information and confidential information, necessary to administer to any program for which I applied or am contracted with, including, but not limited to, my provider agreement with DCF.

I understand all information provided on this application and all information provided to DCF staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any person to obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 21-5801 and amendments, which could be a felony offense punishment by imprisonment, fine or both, and the offender may also be subject to prosecution under other applicable state and federal law.

My signature on this application certifies that I have read and understand these terms and agree to them.

_____ *Print Provider Name*

_____ *Provider Signature (Required)*

_____ *Date (Required)*

Submit this completed form along with a copy of your parent/provider contract or agreement and the Adult Abuse, Neglect, Exploitation Central Registry Release of Information for DCF Child Care Provider Enrollment filled out by all individual(s) 18 years or older who are living, working or volunteering in the facility.

This includes all other individual(s) whose activities involve either supervised or unsupervised access to children.

FOR AGENCY USE ONLY:

Agreement Start Date: _____ End Date: _____

County Code: _____ Provider ID: _____

(DCF) Designee Printed Name: _____

(DCF) Designee Signature: _____ Date: _____

Adult Abuse, Neglect, Exploitation Central Registry Release of Information for
DCF Child Care Provider Enrollment

Please **PRINT ONLY**, except for the signature below.

I, _____, give permission for the release of information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry to: **DCF Child Care Provider Enrollment Unit.**

Maiden Name and/or Other Names Known By: _____

Address: _____
(Street) (City) (State) (Zip Code)

DOB: _____ SSN: _____ SEX: M or F
(mm/dd/yyyy)

I understand that all information released will be for the exclusive and confidential use of the DCF Child Care Provider Enrollment Unit. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, & Exploitation Central Registry each year while I am a DCF Child Care Provider. Name of Provider _____ Yes No (Circle Yes or No)

Applicant Signature:

_____ Date: _____
Must be an Ink Signature

Per KEESM 10035 #1:

DCF cannot enroll a person who is listed as a prohibited person in the Child Abuse/Neglect Central Registry or the Adult Abuse, Neglect, & Exploitation Central Registry and/or listed in [Kansas Adult Supervised Population Electronic Repository \(KASPER\)](#) as being convicted of a felony

<p>DCF Administration Use Only:</p> <p>Date Substantiated: _____</p> <p>Finding - Check all that apply:</p> <p>Abuse _____ Neglect _____</p> <p>Exploitation _____</p> <p>Fiduciary Abuse _____</p> <p>Financial Exploitation _____</p>
