



# 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? \_\_\_\_\_ If Other Please Explain:

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? Yes No  
 Enrollment fee/child: \_\_\_\_\_  
 Enrollment fee/family: \_\_\_\_\_

Do you charge a minimum daily rate? Yes No  
 If yes, your minimum daily rate: \_\_\_\_\_

Do you charge a minimum number of hours/days? Yes No  
 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:

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*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 (Select 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**

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