FDCH APPLICATION FOR PARTICIPATION FOR FAMILY DAY CARE HOMES

Child and Adult Care Food Program • Child Nutrition Programs

Helping Hands, Inc.

APPROVAL TYPE: ☐ **LICENSE** ☐ **RESIDENTIAL CERTIFICATE** ☐ **FFN** ☐ **RELATIVE CARE** ☐ **ALTERNATE CARE**
☐ **NEW** ☐ **TRANSFER**

1) Provider Information: (PRINT CLEARLY)

Name: _____

Address: _____ Apt #: _____

City: _____ Zip:_____

Telephone Number: (_____)_____

Cell Phone Number: (_____)_____

Email Address: _____

Date of Birth: _____

2) Have you or any other member of your household ever participated with another food sponsor? ☐ Yes* ☐ No

*If **yes**, please answer the following:

Name of sponsor: _____

Date last claimed _____

3) Provider's language of choice:

Written_____

Spoken _____

4) Holiday care provided?
☐ Yes ☐ No *If yes*, check holidays care is offered below
☐ President's Day
☐ Memorial Day
☐ Independence Day
☐ Labor Day
(This is for our information only and NOT a preauthorization. You must still *preauthorize* each of these holidays if you wish to claim them.)
New Year's Day, Easter, Thanksgiving, and Christmas, are NOT claimable.

5) Normal hours of care
from AM PM to AM PM

Alternate hours of care
Specify days_____
from AM PM to AM PM

6) Days of week day care is provided:
☐ Sunday ☐ Thursday
☐ Monday ☐ Friday
☐ Tuesday ☐ Saturday
☐ Wednesday

7) Meals claimed:

A. Breakfast	☐ _____ to	_____
B. AM Snack	☐ _____ to	_____
C. Lunch	☐ _____ to	_____
D. PM Snack	☐ _____ to	_____
E. Dinner	☐ _____ to	_____
F. Eve Snack	☐ _____ to	_____

(A minimum of **2 hours** between the starting times of each meal/snack)

Alternate meal times/days: (if applicable)
Specify alternate days/or if split shift:_____

A. Breakfast	☐ _____ to	_____
B. AM Snack	☐ _____ to	_____
C. Lunch	☐ _____ to	_____
D. PM Snack	☐ _____ to	_____
E. Dinner	☐ _____ to	_____
F. Eve Snack	☐ _____ to	_____

8) Is there a second or substitute caregiver?
☐ Yes ☐ No
If yes, list name(s):_____
Phone(s): _____

9) Provider works outside home ☐ Yes ☐ No
If yes, hours of work: from _____ to _____
Place of work:_____
Work phone: _____

10) Licensed / Certified / FFN providers only (as of date FDCH Application signed)
A. Expiration date _____
B. Capacity _____

11) Relative Care Providers only:
I certify that all outside children for which I provide care are either siblings (including "step"), grandchildren (including "step" & "great"), Nieces/Nephews (including "step:"&"great") ONLY **Provider's Initials** _____

Relative and Alternate Care Providers only:
I certify that I will complete and maintain a current background check for all individuals in my household 12 years and older **Provider's Initials** _____

13) Have you ever been denied a state child care license, residential certificate or FFN approval?
☐ Yes ☐ No When? _____ Explain:

12) Number of:
A. Children under 2 _____
B. Own children _____
C. Non-Resident day care _____

Number of provider's own children under 4 years of age: _____

17) Ethnicity:
☐ Hispanic
☐ Non-Hispanic

18) Race:
☐ American Indian or Alaskan Native ☐ Asian
☐ Black ☐ Pacific Islander ☐ White

(Answering these questions is optional; however, the information is federally required for Helping Hands, Inc. If you choose not to answer, Helping Hands, Inc. will complete them to the best of their ability)

I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; and that department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes. I certify that I am not currently enrolled under any other Sponsoring Organization of the Family Day Care Home Program.

Signature of provider:	**Date**	**Signature of sponsor acknowledging receipt:**	**Date of receipt:**

This institution is an equal opportunity provider. **06-18**