FDCH APPLICATION FOR PARTICIPATION FOR FAMILY DAY CARE HOMES

Child and Adult Care Food Program ▪ Child Nutrition Programs ▪ USBE

Orem Child Care Nutrition Program

APPROVAL TYPE: ☐ **LICENSE** ☐ **RESIDENTIAL CERTIFICATE** ☐ **RELATIVE CARE** ☐ **ALTERNATE CARE**
☐ **NEW** ☐ **TRANSFER** ☐ **CHANGE** ☐ **RENEWAL** ☐ **INACTIVE (date:_____)**
TIER CLASSIFICATION: ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 2 Mixed**

(Office Use Only)

1) Provider's Identification Number_____

2) Renewal Effective Date (month) _____ 20____ (enter month agreement was signed and current year; this application is good for one year from this date.)

3) Provider Information: (PRINT CLEARLY)

Name: _____

Address: _____ Apt #: ____

City: _____ Zip:_____

Telephone Number: (_____)_____

Cell Phone Number: (_____)_____

Email Address: _____

Date of Birth: _____

4) (*Initial application only)* 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 _____

Provider's language of choice:
Written_____
Spoken _____

5) Income eligible for Provider's own children (office use only): Yes ☐ No ☐

6) Tiering Determination – School, Census or Income (office use only)
A. ☐ **School**
District: _____
School_____
Expiration date:_____
B. ☐ **Census**
Block number:_____
Expiration date:_____
C. ☐ **Income**
Expiration date:_____

7) Holiday care provided?
☐ Yes ☐ No *If yes*, check holidays care is offered below
☐Martin L. King Day
☐ President's Day
☐ Memorial Day
☐ Independence Day
☐ Labor Day
The following holidays are approved for reimbursement when providing care. Sign in/out sheet(s) required.
****New Years Day, Easter, Thanksgiving, & Christmas will not be reimbursed.**

8) Normal hours of care
from AM PM to AM PM
Alternate hours of care
Specify days_____
from AM PM to AM PM

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

10) 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 _____

11) Is there a second or substitute caregiver?
☐ Yes ☐ No
If yes, list name(s):_____
Phone(s): _____
(For Rel. Care or Alt Care providers please submit a BCI for all listed)

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

13) ☐ **Licensed / Certified**
☐ **Relative Care/Alternate Approval**
A. Expiration date _____
B. Capacity _____
Number of:
C. Children under 2 _____
D. Own children _____
E. Non-Resident day care _____

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

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

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

16) Have you ever been terminated from the Food Program?
☐ Yes ☐ No When? _____ Explain:

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 Alliance for Children
If you choose not to answer, Alliance for Children will complete 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 representative:**	**Date:**

Provider Name:

FDCH Application Change Form

☐ **CHANGE** ☐ **REACTIVATE Effective Date**_____ ☐ **INACTIVE Effective Date**_____

Address_____**City**_____**Zip**_____

TIER CLASSIFICATION: ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 2 Mixed**

Amendment to Application Meals

8) What hours care is provided:
from to

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

11) **Meals claimed:**

A. Breakfast	☐ _____	to _____
B. A.M. Snack	☐ _____	to _____
C. Lunch	☐ _____	to _____
D. P.M. Snack	☐ _____	to _____
E. Dinner	☐ _____	to _____
F. Eve. Snack	☐ _____	to _____

(minimum of **2 hours** between meal / snacks required)

Alternate meal times/days/shifts: (optional)

A. Breakfast	☐ _____	to _____
B. A.M. Snack	☐ _____	to _____
C. Lunch	☐ _____	to _____
D. P.M. Snack	☐ _____	to _____
E. Dinner	☐ _____	to _____
F. Eve. Snack	☐ _____	to _____

Specify alternate days:_____

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