

Day Care Home Provider Application

Institution Information		
Institution Name	Agreement Number	Program Year
		2018-2019

Action: (select <u>one</u>)	<input type="radio"/> Add	<input type="radio"/> Drop	<input type="radio"/> Change
-------------------------------------	---------------------------	----------------------------	------------------------------

Day Care Home Provider Information							
Provider Name:	First	Middle	Last	SSN: 999-99-9999			
Street Address:				Registration Type: (select <u>one</u>)	<input type="radio"/> License	<input type="radio"/> Military	<input type="radio"/> Alternate Approval
Mailing Address :				Registration/ License No:			
City:				Effective Date: (MM/DD/YYYY)	Month	Day	Year
State:		Zip Code:		Phone: ()			
County:				Email:			

Meal Times (check all that apply \checkmark)									
Meal	Begin	End	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Breakfast			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning Snack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lunch			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon Snack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supper			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening Snack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provider Name _____

Provider's Eligibility

Yes No

Provider eligible to claim own children?

Months Approved for the Fiscal Year (check all that apply ✓)

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tier Information (select only one)

Tier Level:

Tier 1

Tier 2 Low

Tier 2 Mixed

Tier 2 High

Date of DCH Provider's tier classification:

Month

Day

Year

Circle Source of Tier Data (A, B, C, D)

Tier I	A.	Name of elementary school:
		% Needy
		Year of school data
	B.	Provider Income: _____ / year / month / week or Food Stamp #
		Family Size: _____
	C.	Census Data (year 2010)
Tier II	D.	Does the Day Care Home Provider request that the Sponsoring Organization obtain eligibility applications from participants' families in order to document Tier status and possible higher reimbursement rates? <input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that this Day Care Home Provider Application is true and correct, and that it is in accordance with the terms of existing Agreement(s). I further understand that this information is being given in connection with the receipt of Federal funds and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

Sign Here ►

Keep Original for your records.

Signature of Sponsoring Organization Authorized Representative

Date of Preparation

Printed Name of Sponsoring Organization Authorized Representative