

**All new applications would be provisional and for 1 year**

**Please check one:**

DO YOU HAVE A SWIMMING POOL?

( ) New Application

( ) Renewal Application

\*If renewal please add:

Certificate # \_\_\_\_\_

\_\_\_\_ YES

\_\_\_\_ NO

\_\_\_\_ ABOVE GROUND

\_\_\_\_ IN GROUND

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF LICENSING & REGULATORY SERVICES

**APPLICATION FOR A CERTIFICATE TO OPERATE A FAMILY CHILD CARE**

Please complete the following **two-year** application for Family Child Care Certification and return it with a check or money order made payable to **TREASURER, STATE OF MAINE. The \$160.00 application fee is non-refundable.** Mail to:

Department of Health and Human Services  
Division of Licensing & Regulatory Services  
Community Services Programs  
41 Anthony Avenue, 11 State House Station  
Augusta, ME 04333-0011

**Applicant**

Print/Type Name: \_\_\_\_\_ Name of Facility: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Any Former Names: \_\_\_\_\_ Social Security or IRS Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ P.O. Box \_\_\_\_\_

Town: \_\_\_\_\_ Zip code: \_\_\_\_\_ E-mail: \_\_\_\_\_

Town of Residence: \_\_\_\_\_ Telephone: \_\_\_\_\_

**CHILD CARE FAMILY:**

Members of Household Other Than Child Care Provider:

<u>Name</u>	<u>Birth Date</u>	<u>Social Security #</u>	<u>Relationship to Applicant</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use additional sheet of paper if necessary)

- FOR OFFICE USE ONLY -

LICENSING WORKER: \_\_\_\_\_ FULL ( ) PROV ( ) TEMP ( )

CAPACITY: \_\_\_\_\_ EFFECTIVE: \_\_\_\_\_ EXPIRES: \_\_\_\_\_

INSPECTION DATE: \_\_\_\_\_ ID#: \_\_\_\_\_

SOURCE OF WATER (CHECK ONE): MUNICIPAL ( ) PRIVATE ( )

( ) CHECK HERE IF YOU WOULD LIKE A WATER TEST KIT MAILED TO YOU. ( ) SIGNED BOTTLED WATER AGREEMENT ON FILE

**What Year Was Your Home Built?** \_\_\_\_\_

**Directions to the Home:** (Be specific and as detailed as possible. No maps please)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Best time of day to visit: \_\_\_\_\_

**Largest Number of Children to be in your care at any time:**  
(You are not required to count your own children).

3 – 6 ( )                      7 – 12 ( )

**Names, Addresses and Phone Numbers of All People Working with Children:** (Use additional sheet of paper if necessary.)

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_

**Other Licenses:**

Are you now, or have you ever been licensed, registered or certified to provide services for children or adults?  
Yes ( ) No ( )

If yes, please indicate the type of care, approximate dates of service and name(s) under which you were licensed:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any prior sanctions such as a conditional certificate, certificate suspension, fine or revocation regarding a child or adult care certificate or approval issued to you? ( ) Yes ( ) No If Yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOUR HISOTRY:** Please use additional sheets of paper if necessary to explain your responses to these questions. Have you or has anyone employed by you or living in or frequenting your home been involved in the following:

- 1) Convicted of a crime; ( ) Yes ( ) No
- 2) Involved in a child protective investigation; ( ) Yes ( ) No
- 3) Named as a defendant in a Protection from Abuse Order; ( ) Yes ( ) No
- 4) Had children removed from their care or custody by court order. ( ) Yes ( ) No
- 5) If you are a renewal applicant, have you had any of the above in the last year? ( ) Yes ( ) No

If you checked yes to any of the above, please explain:

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Have you ever been treated for drug or alcohol abuse? Yes ( ) No ( )

If yes, please explain: \_\_\_\_\_

Have you ever received mental health services? Yes ( ) No ( ) If yes, please explain:

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Is there any other information that would be useful in assessing your ability to provide care for children?

Yes ( )                      No ( )                      If yes, please explain:

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I/We have received and read the “Rules for Family Child Care Providers”. I/We understand that this application authorizes representatives of the Department and the State Fire Marshall’s Office to make such visits and inspections as may be necessary to ascertain that the facility is in compliance with the LAW and RULES pertaining to the operation of such facilities.

I/We further certify that all information contained in this application is complete and accurate. I/We understand that misrepresentation may be cause for denial or revocation of my Home Day Care Certificate.

Applicant’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Applicant’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTORIZATION FOR THE RELEASE OF PERSONAL HISOTRY INFORMATION FOR ALL ADULT MEMBERS OF HOUSEHOLD/STAFF**

By signing below, I authorize the release of confidential records or information regarding any **criminal record, child protection record or motor vehicle record** to the Department of Health and Human Services, Division of Licensing and Regulatory Services, Community Services Programs.

I understand that any information obtained as a result of this release of information will remain confidential, as required by law, and will be used solely for the purpose of determining whether a license or approval to operate a children's daycare or other license should be granted or renewed.

Also, if any criminal record, child protection record or motor vehicle record indicates that a prior conviction or finding exists, the applicant will need to provide evidence to the Division of Licensing and Regulatory Services that any prior history has been addressed and the individual will not compromise or threaten the safety of any children to be cared for by the applicant.

This consent may be revoked by me, in writing , at any time, except that information that has already been obtained.

I understand that each adult member of my household or staff/volunteers must complete the lower portion of this form and that failure to do so will invalidate my application.

**For adult household members and staff/volunteers: By signing below, adult household members and staff/volunteers authorize the Department of Health and Human Services, Division of Licensing & Regulatory services to disclose confidential records or information regarding that person's criminal, child protection, or motor vehicle record to the applicant/provider.**

Please sign this form and return it to: Department of Health and Human Services, Division of Licensing & Regulatory Services, Community Services Programs, 41 Anthony Avenue, SHS #11, Augusta, ME 04333-0011. Without this signed release, the application cannot be approved and the applicant will be denied permission to operate.

**Provider's Information**

Provider's Full Name: \_\_\_\_\_ Former/Maiden names: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Signature: \_\_\_\_\_

**Adult Household Members and Staff/Volunteers Information**

Full Name: _____	Full Name: _____
Street Address: _____	Street Address: _____
City, State & Zip: _____	City, State & Zip: _____
Telephone #: _____	Telephone #: _____
Date of Birth: _____	Date of Birth: _____
Former/Maiden Names: _____	Former/Maiden Names: _____
Social Security #: _____	Social Security #: _____

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Full Name: _____	Full Name: _____
Street Address: _____	Street Address: _____
City, State & Zip: _____	City, State & Zip: _____
Telephone #: _____	Telephone #: _____
Date of Birth: _____	Date of Birth: _____
Former/Maiden Names: _____	Former/Maiden Names: _____
Social Security #: _____	Social Security #: _____

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_