Provider Application

Office Phone Number: (703) 784-2011

Dear Applicant:

Thank you for your interest in the Family Child Care (FCC) Program. The following provide information regarding the process of becoming an FCC Provider. If you have any questions or concerns, please contact the FCC office at 784-2011.

APPLICANT PROCEDURES

a. Complete the following application attachments and return them to the FCC Office: (i) Application, (ii) Request To Operate an FCC Home, (iii) Authorization For Release of Information.

b. Your background screenings will be conducted by the following agencies: Command Substance Abuse Counseling Center, Family Advocacy Program, Housing, Behavioral Health, Provost Marshal's Office, Naval Criminal Investigative services.
Background checks must be initiated before the start of training.

c. Attend initial FCC orientation training to include American Red Cross CPR and First Aid for a fee. If you wish, you may obtain your Red Cross certifications from another agency.

d. Obtain a Health Card from the Health Clinic. Contact Occupational Health at (703) 784-1673 for an appointment. Occupational Health will not be able to accommodate applicants who bring their child/ren with them. All medical records will be released for screening at this time. Provide the FCC office with a copy of your Health Card.

e. Upon completion of orientation training, contact the FCC office to schedule command inspections by Fire, Safety, and Sanitation Departments. Inspection procedures will be covered at orientation training.

f. Liability insurance is required of all FCC Providers through an approved insurance company. You may either pay on line or mail your application to the company. Insurance information is covered at orientation training.

g. Once the above requirements are met, you may be granted permission to operate a Family Child Care home.

Date:_____

From:_____ _____
Sponsor Rank and Name Applicant Name

To: Director, Family Child Care
Marine and Family Services
3311 Purvis Road
Quantico, VA 22134-5001

Subj: REQUEST TO OPERATE A FAMILY CHILD CARE HOME

Ref: (a) MCCDCO 1754.1A
(b) FCC SOPs
(c) MCO 1710.30E
(d) Lincoln Military Housing Lease Agreement

1. In accordance with the above references, I hereby request permission to operate a Family Child Care (FCC) home in my Lincoln Military residence.

2. I agree to bear responsibility for all damages and/or restoration costs to my quarters, other than normal "wear and tear". Structural changes may not be made to provide FCC services without written permission from Lincoln Military Housing.

3. I understand the rights of other service members and their dependents to the use and quiet enjoyment of military family quarters must not be hindered by my FCC operations.

4. I agree to insure that the parents of all children under my care will have a completed, signed, and witnessed all required child care record forms prior to services incurred.

5. I will submit a completed FCC monthly report to the FCC office by the second work day of each month reflecting the previous month's child care services in my home.

6. I understand that any violation of stated rules set forth both locally and by Headquarters Marine Corps may result in termination of my permission for operating a Family Child Care home.

7. I further agree to assume all risks associated with the use of Lincoln Military quarters for the purpose of providing private child care services. **I will neither seek any cause of action against, nor indemnification by the U.S. government, its agencies, or employees for any personal liability incurred as a result of my operation of my child care program.**

8. My permission is given to obtain information from appropriate persons or agencies for the purpose of completing background screening procedures required to become a Family Child Care provider. It is understood that this information will be used in my best interest and will be held in confidence.

9. I understand that child care must be provided on a nondiscriminatory basis, according equal treatment and service.

10. I understand that when changes to my information on this application packet occur, I must contact the FCC office to update my file.

FAMILY CHILD CARE APPLICATION

APPLICANT NAME (Last, First, MI)	SSN:	DOB:
SPONSOR NAME (Rank, Last, First, MI)	SSN:	DOB:
ADDRESS:	HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	SPOUSE DUTY STATION/PHONE:	# OF CHILDREN:

Household Members (including self, sponsor, and all dependents)

NAME	DOB	RELATIONSHIP	BIRTH PLACE (CITY, STATE & ZIP CODE)

BACKGROUND INFORMATION:

1. Were you referred to the FCC Office? _____
If yes, by whom? _____

2. What is the last grade you completed in school? _____
(Minimum requirement: High school diploma or equivalent). **PROVIDE A COPY OF YOUR DIPLOMA OR GED.**

3. Have you had any previous training which will help you as an FCC provider? Please describe. Provide training record if available.

_____
_____
_____
_____

4. What are your experiences in caring for/working with children?

_____
_____
_____
_____
_____
_____
_____

5. How do you handle discipline problems in your home?

_____
_____
_____
_____
_____
_____
_____

6. How would you react to a child who bites or swears?

_____
_____
_____
_____
_____
_____
_____

7. Do you have any pets? If yes, describe breed. Provide copy of shots.

_____
_____
_____
_____

8. Do you or anyone in your family smoke?_____

9. What contribution(s) can you make to the Family Child Care Program?

_____
_____
_____
_____
_____
_____
_____

10. What are your strongest attributes in terms of becoming a certified home day care provider?

_____
_____
_____
_____
_____
_____
_____

I attest the above information is true and correct to the best of my knowledge.

_____ _____

Applicant signature Date Sponsor signature Date

Personal References: Three individuals other than relatives. Distribute the Personal Reference Check (page 7) to each of your three references. Collect all three and return with your application packet.

Family Child Care
Quantico, VA 22134
Personal Reference Check

FCC Applicant's Name:_____

Name of person submitting information:_____

Address:_____ Phone:_____

How long have you known the applicant? _____
As a friend, co-worker, neighbor? Circle those that apply.

To your knowledge, does this applicant

	YES	NO	U/K	NA
1. Relate to children and adults in a sensitive and positive manner?				
2. Act responsibly in crisis situation?				
3. Maintain a safe and sanitary home?				
4. Have the stamina, patience and capability to care for children for sustained time periods?				
5. Have any animals that might pose a threat to children's well-being?				
6. Show any evidence of mental health or alcohol problems, which could adversely affect the health, or safety of children in care?				
7. To your knowledge, has there been any convictions of, admissions to, or substantive evidence of an act of child abuse (i.e., battering, molesting, etc.) or neglect by this applicant or by any family member?				
8. Is there any reason you feel that this applicant should not be considered as a participant in the Family Child Care Program?				

Comments:_____
_____
_____
_____
_____
_____

_____ _____
Signature Date

Family Child Care
Quantico, VA 22134
Personal Reference Check

FCC Applicant's Name:_____

Name of person submitting information:_____

Address:_____ Phone:_____

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Comments:_____
_____
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_____ _____
Signature Date

Family Child Care
Quantico, VA 22134
Personal Reference Check

FCC Applicant's Name:_____

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Comments:_____
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_____
_____

_____ _____
Signature Date

CHILDREN, YOUTH AND TEEN PROGRAMS
QUANTICO VA

AUTHORIZATION FOR RELEASE OF INFORMATION

PRIVACY ACT STATEMENT

The authority for requesting social security numbers is Executive Order 9397. Social Security numbers will be used by Family Child Care in accomplishing background checks to determine suitability in meeting qualification requirements outlined in OPNAVINST 1700.9C. Disclosure of this information is voluntary; however, failure to do so will result in disapproval of the applicant to provide child care services in government quarters and in private homes managed by the Quantico FCC program.

As part of the investigative process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations:

- Does the person have a condition or treatment that could impair his/her judgment or reliability?
- If so, please describe the nature of the condition and the extent of the impairment or treatment.
- What is the prognosis?

PRINTED NAME OF APPLICANT	PRINTED NAME OF SPONSOR
DOB SSN /	DOB SSN /
SIGNATURE AND DATE	SIGNATURE AND DATE

Names, Social Security Numbers and DOB of additional household members over the age of twelve:

1. PRINTED NAME	2. PRINTED NAME
DOB SSN /	DOB SSN /
SIGNATURE AND DATE	SIGNATURE AND DATE
3. PRINTED NAME	4. PRINTED NAME
DOB SSN /	DOB SSN /
SIGNATURE AND DATE	SIGNATURE AND DATE