Family Child Care Home Initial Application Checklist

Dear Family Child Care Applicant: Thank you for your interest in Family Child Care Home licensing. Please follow the instructions below to apply for the license.

1. **Submit an Application Packet** Complete each form listed below in blue or black ink and answer all the questions completely. We will begin processing your application as soon as we receive the Application Fee and the Application Form. You may send the rest of the forms as soon as they are completed. Since the fingerprint responses can take at least 90 days, it is beneficial to submit them as early as possible.

   - **Application** Be sure to answer all of the questions completely.
   - **$40 Application Fee** Make your check payable to “Treasurer State of Connecticut”. This fee is not refundable.
   - **“Adult Medical Statement for Child Care”** for all household members 18 years of age or older. Physical examination and TB test must have been within the past year. Form can be found at: [www.ct.gov/oec](http://www.ct.gov/oec)
   - **“CT Early Childhood Health Assessment Record”** (for children ages birth to 5) or **Health Assessment Record** (for school age children) for each household member under 18 years of age. Physical examination must have been within the past year or up to date with the school’s requirement and immunizations must be up to date.
   - **First Aid Certification** – A copy of a certificate, front and back, documenting the successful completion of an approved course in first aid approved for child care providers. A list of approved First Aid Courses can be found at: [www.ct.gov/oec](http://www.ct.gov/oec)
   - **Foster Care or Adoption Verification Form** – required if you have ever applied for, held or currently hold a foster care or adoption license in CT or any other state.
   - **If you have a well**, you must submit a well water test by a state certified laboratory completed within the past year. (Refer to Regulation Section 19a-87b-9(i) for a list of required tests.
   - **References** – Submit three Request for Reference Forms to be completed and signed by individuals (no more than one relative) that have known you for at least three years.
   - **Fingerprints and Fingerprint Fee** - Submit one fingerprint card (green) for each household member 16 years of age or older. Please read the Fingerprinting Packet instructions carefully to ensure accuracy when submitting the packet to the Legal Office.
   - **DCF “Authorization for Release of Information”** one for each household member 16 years of age and older.

If you have obtained this application on-line, please call the Connecticut Office of Early Childhood @ 860-500-4466 to obtain a fingerprint packet.

2. **Have an Initial Inspection of your home**
   **Once your application is complete**, we will contact you to schedule an inspection of your home. During the inspection we will discuss the Family Child Care Home Regulations with you, answer any questions you may have and make sure your home complies with the Regulations. **Please read and be familiar with the Regulations before your appointment.** You can access them online at: [www.ct.gov/oec](http://www.ct.gov/oec) or call 800-282-6063 to request a copy in the mail. **Note:** We cannot schedule an inspection of your home until your application is complete.
The licensing fee along with this Initial Application Fee Invoice Form is due with your application to obtain a child care license. **THE FEE IS NON-REFUNDABLE.**

Please complete items 1 through 10 of this form. If you have questions, call the licensing office at 1-800-282-6063 or (860)500-4450. Make your payment by check or money order payable to: TREASURER-STATE OF CONNECTICUT. Mail this form along with your payment and application to the Connecticut Office of Early Childhood, 450 Columbus Boulevard, Suite 302, Hartford, CT 06103.

1. Name of Applicant:  
   ____________________________________________________________________________  
   (Legal Operator)

2. Program Name:  
   ____________________________________________________________________________  
   (Applicable For Group/Center Only)

3. Program Location Address:  
   ___________________________________________  City/Town  Zip Code

4. Program Phone Number: (____) _____ - _______ Program Fax Number: (____) _____ - _______

5. Mailing Address (if different):  
   ___________________________________________  City/Town  Zip Code

6. Program E-mail Address:  
   ____________________________________________________________________________

7. Enclosed Check/Money Order: $__________Check #: __________ Check Date: _____/_____/_____

8. Social Security #: __________ - _______ - _______ Federal Employer ID: __________ - _______  
   (3 digits)  (2 digits)  (4 digits)  (2 digits)  (7 digits)

9. **Proof of Worker’s Compensation Insurance:** Do you hire employees in your program that require Worker’s Compensation? ☐ Yes ☐ No  
   If yes, please complete the following:
   
   Name of Insurer: __________________________ Insurance Policy #: __________________________  
   Effective Dates of Worker’s Compensation Coverage: _____/_____/______ to _____/_____/______

10. Payment is for the following type of license: (check one box below)

<table>
<thead>
<tr>
<th>Child Care Center (Account #42431)</th>
<th>Group Care Home (Account #42431)</th>
<th>Family Care Home (Account #42431)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 4-year license (new program)</td>
<td>☐ 4-year license (new program)</td>
<td>☐ 4-year license (new provider)</td>
</tr>
<tr>
<td>$500.00</td>
<td>$250.00</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

Affirmative Action/Equal Opportunity Employer
Connecticut Office of Early Childhood
Family Child Care Home

Initial Application for Licensure

GENERAL INFORMATION
Please type or print. Use an extra page if necessary.

1. Applicant’s Name: __________________________          ____________________________
   first           middle          last

2. Date of Birth: __________________________
   Home Telephone: (_______)___________________________
   Work Telephone: (_______)__________________________
   Cell Telephone: (_______)__________________________

3. List all former names you have been known by:
   ________________________________________________
   ________________________________________________

4. Location/Street Address: ____________________________________________

5. City, Town, Zip: ____________________________   CT    __________________
   city/town          zip code
   Mailing Address (if different): ______________________________________

6. List all your addresses for the past five years:
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________

7. □ Yes    □ No  Have you ever applied for a child day care license in Connecticut or in any other
   state? If yes, when and where? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

8. □ Yes    □ No  Have you ever held a child care license in Connecticut or in any other state? If yes, when
   and where? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   Agency Name: ____________________________________________
   Agency Address: ____________________________________________
   Agency Telephone Number: ____________________________________________
9. □ Yes □ No  Have you ever applied for, held, or currently hold a foster care or adoption license in Connecticut or any other state? If yes, you are required to ensure that the enclosed “Foster Care or Adoption License Verification” form is completed by the respective Foster Care Licensing Agency and forwarded to the Office of Early Childhood.

10. □ Yes □ No  Have you ever been disciplined, terminated or put on probation from any position you held for child care? If yes, please explain.

   Program Name: ________________________________________________________________
   Program Address: ______________________________________________________________________________
   Program Telephone Number: __________________________________________________________________________

11. □ Yes □ No  Are you currently employed outside of home? If yes, describe the job and your hours of employment: ______________________________________________________________

12. □ Yes □ No  Do you plan to continue outside employment after you are licensed/approved? If yes, please explain: _____________________________________________________________________

13. What will be your customary business hours?

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

14. Identify an emergency back-up caregiver, a responsible adult (at least 20 years of age) who is able to arrive at the facility within ten (10) minutes:

   Name: _______________________________________________________ Phone (_____) _________________
   Street Address: __________________________________ City/Town: ______________ State: _____ Zip Code: ______
   Work Address: ___________________________ City/Town: ______________ State: _____ Zip Code: _____
15. Please list all the adults and children who reside in the family child care home (INCLUDING YOURSELF):

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Relation to You</th>
<th>Date of Birth</th>
<th>Times Present in the Home per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

16.  □ Yes □ No  Do you, or does any person living in the home used for child care, have any known medical or emotional illness or disorder that would pose a risk to children in care or would interfere with or jeopardize providing them with proper care? If yes, please explain:

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

17.  □ Yes □ No  Do you, or does any person living in the home used for child care, take any medication(s) that would affect your ability to provide for the proper care of children? If yes, please explain:

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

18.  List all staff (assistants and substitutes) in the family child care home. (All staff must be pre-approved by the Agency. Please request a staff application if you intend on using individuals as staff to work at your program.

<table>
<thead>
<tr>
<th>Name</th>
<th>Complete Mailing Address Including Zip Code</th>
<th>Telephone #</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
19. □ Yes □ No  Will you provide care in the home in which you live? If no, please provide us with the following information:

Name of Home Owner: __________________________________________________

Facility Address: ______________________________________________________

Facility Telephone Number: ___________________________________________

20. □ Yes □ No  Was the residence in which you will be providing child care constructed before 1978?

PLEASE NOTE: Samples of peeling paint chips will be collected for lead testing at the time of your initial inspection.

21. □ Yes □ No  Does the residence in which you will be providing child care consist of three (3) or more dwelling units (apartments)?

22. □ Yes □ No  Does the home have an auxiliary heating device, i.e., wood stove, space heater? If yes, you must enclose written proof that it was inspected and approved for proper and safe installation. (Section 19a-87b-9(d)(8)).

□ Yes □ No  Inspection report enclosed.

23. □ Yes □ No  Is the home served by a public water supply? If no, you must enclose written proof from a state certified laboratory that the water was tested within the last year and is potable, adequate and safe (Section 19a-87b-9i).

□ Yes □ No  Water test enclosed.

24. □ Yes □ No  Is the outdoor play area protected from traffic, bodies of water, gullies and other hazards by barriers, in a manner safe for children?

Note: Where there is a swimming pool or any other body of water at the facility or near enough to the facility to attract or be accessible to children at any time of the year, there shall be a sturdy fence/barrier, four (4) feet high or higher, with locked entrances which totally and effectively bars access to the water by the children in care.
CONNECTICUT OFFICE OF EARLY CHILDHOOD  
Division of Licensing  

STATEMENT OF COMPLIANCE  

Applicant’s Name: _____________________  ______________________  ______________________  
  First                  Middle                  Last  

Address of Facility: ___________________________  ___________________________  
  Street                  Town                  State                  Zip  

I certify that I have read, am familiar with, and understand the regulations for the licensure of family child care homes adopted by the Commissioner of the Office of Early Childhood pursuant to Connecticut General Statutes Section 19a-87b(f). I agree to maintain a copy of these regulations at the facility, maintain my family child care home in compliance with these regulations, and I will allow home visits by Agency staff to the family child care home.  

I certify that all children enrolled in the family child care home have received age-appropriate immunizations in accordance with Section 19a-87b-10(k) of the regulations for the licensure of family child care homes.  

NOTICE OF PENALTY FOR FALSE STATEMENTS  

Under the law, all information provided on this application form, or in any statements accompanying this application, must be truthful. Any false statements could cause the denial of this application and may be punished as a Class A Misdemeanor under Section 53a-157b of the Penal Code. This notice is given as required by the Connecticut General Statutes, Section 19a-87b(a).  

Understanding the penalties for false statements, I attest that my statements in this application are true, to the best of my knowledge and belief.  

X_________________________________________  ______________________  
  (Signature of Applicant)                  (Date)
Please check one of the following boxes:

- Family Child Care Home Applicant
- Family Child Care Home Staff Assistant Applicant
- Family Child Care Home Staff Substitute Applicant
- Family Child Care Home Provider - License # _____________ Expiration Date ________
- Family Child Care Home Staff Assistant – Approval # ______ Expiration Date ________
- Family Child Care Home Staff Substitute – Approval # ______ Expiration Date ________
- Group Child Care Home Employee / Child Day Care Center Employee
- Adult Member of Household

<table>
<thead>
<tr>
<th>Patient’s Name ____________________________</th>
<th>Phone # ________________</th>
<th>Date of Birth <em><strong>/</strong></em>/___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address ____________________________</td>
<td>Town ____________________</td>
<td>Zip Code _________________</td>
</tr>
</tbody>
</table>

This section must be completed by a Physician, Physician Assistant or Advanced Practice Registered Nurse:

This medical clearance is an important requirement in day care licensing laws designed to protect the health, safety and welfare of the children in care.

1. To the best of your knowledge, does this person have any medical or emotional illness or disorder that would currently pose a risk to children in their care or would interfere with or jeopardize a caregiver’s ability to render proper care for children in the child care facility?  
   - YES  
   - NO

If yes, please explain: __________________________________________________________________________________________________

2. Date of patient’s MOST RECENT examination: __________________

3. Required check for Tuberculosis:  
   - Tuberculin skin test Date _________________ □ Positive □ Negative
   - Chest x-ray Date _________________ □ Positive □ Negative

4. Medical Provider’s Information  
   - Name: ____________________________________________
   - Address: __________________________________________
   - Phone #: _________________________________________

5. ____________________________________________ / ________________________
   - Signature of MD, APRN or PA
   - Date

Connecticut Office of Early Childhood  
450 Columbus Boulevard  
Suite 302  
Hartford, CT 06103  
Phone# 1-800-282-6063 or (860)500-4450  
Fax# 860-326-0552
State of Connecticut

Early Childhood Health Assessment Record

To Parent or Guardian:

In order to provide the best experience, early childhood providers must understand your child’s health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Please print

<table>
<thead>
<tr>
<th>Name of Child (Last, First, Middle)</th>
<th>Social Security Number</th>
<th>Birth Date</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street)</td>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Town and ZIP code)</td>
<td>American Indian</td>
<td>White, not of Hispanic origin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>Hispanic/Latino</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black, not of Hispanic origin</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian (Last, First, Middle)</td>
<td>Home Phone Number</td>
<td>Work/Cell Phone Number</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Provider</td>
<td>Preferred Hospital</td>
<td>Health Insurance Company/Number* or Medicaid/Number*</td>
<td></td>
</tr>
</tbody>
</table>

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

Important: Complete Part I before your child is examined. Take this form with you to the health care provider’s office.

Please check answers to the following questions in columns on the left.
(Explain all “yes” answers in the space provided below.)

Yes  No

1. □  □ Do you have any concerns about your child’s general health, development or behavior?
2. □  □ Has your child been diagnosed with any chronic disease □ asthma □ diabetes □ seizure disorder □ other ____________________________
3. □  □ Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: ____________________________
4. □  □ Does your child take any medications (daily or occasionally)?
5. □  □ Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6. □  □ Has your child had any hospitalization, operation, major illness or injury, or significant accident?
7. □  □ In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?
8. □  □ In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
9. □  □ Has your child had a dental examination in the last 12 months?
10. □ □ Would you like to discuss anything about your child’s health with the child care provider or health consultant/coordinator?

Please explain any “yes” answers here. For illnesses/injuries/etc., include the year and/or your child’s age at the time.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

I give permission for release of information on this form for confidential use in meeting my child’s health and educational needs in the early childhood program.

Signature of Parent/Guardian ___________________________ Date ______________

ED191 REV. 8/2004 C.G.S. Section 10-16q, 10-206, 19a-79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

To be maintained in the child’s Health Record
### Chronic Disease Assessment:

- **Asthma:**
  - mild
  - moderate
  - severe
  - exercise induced
  - unclassified

- **Diabetes:**
  - Type I
  - Type II

- **Anaphylaxis:**
  - food
  - insect
  - latex

- **Seizures:**
  - Type

- **Other:** Please specify

### Other:

- **Vision:**
- **Auditory:**
- **Speech/Language:**
- **Physical Dysfunction:**
- **Emotional/Social:**
- **Behavior:**

This child has the following problems which may adversely affect his or her educational experience:

- Vision
- Auditory
- Speech/Language
- Physical Dysfunction
- Emotional/Social
- Behavior

*Prior to Public School Entry: Same as above and Hgb/hct.*

---

**Part II — Health Evaluation**

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

<table>
<thead>
<tr>
<th>Screening/Test Results</th>
<th>Immunization Record</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Vaccine (Month/Day/Year)</td>
</tr>
<tr>
<td>Test type:</td>
<td>Dose 1</td>
</tr>
<tr>
<td><strong>Hearing</strong>&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Test type:</td>
<td>DTP/Hib</td>
</tr>
<tr>
<td><strong>Lead</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Risk: Yes/No</td>
<td>OPV</td>
</tr>
<tr>
<td><strong>Urinalysis (UA)</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>IPV</td>
</tr>
<tr>
<td><strong>Anemia</strong>&lt;sup&gt;6&lt;/sup&gt;</td>
<td>MMR</td>
</tr>
<tr>
<td>(Hgb/HCT)</td>
<td>Measles</td>
</tr>
<tr>
<td>Risk: Yes/No</td>
<td>Mumps</td>
</tr>
<tr>
<td><strong>Developmental</strong>&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Rubella</td>
</tr>
<tr>
<td><strong>Assessment</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>HIB</td>
</tr>
<tr>
<td>Test type:</td>
<td>Hep B</td>
</tr>
<tr>
<td><strong>Has this child received dental</strong></td>
<td>Varicella</td>
</tr>
<tr>
<td><strong>care in the last 12 months?</strong>&lt;sup&gt;9&lt;/sup&gt;</td>
<td>PCV</td>
</tr>
<tr>
<td>Yes ❑ ❑ No ❑ ❑ N/A</td>
<td>Other Vaccines (Specify)</td>
</tr>
</tbody>
</table>

| Minimum requirements: | 1 Up to 2 years; 2 annual at 3 years; 3 annual at 4 years; 4 as needed; 5 9–12 months; 6 each visit through 5 years; 7 annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary. | 8 Prior to Public School Entry: Same as above and Hgb/hct. |

This child has the following problems which may adversely affect his or her educational experience:

- Vision
- Auditory
- Speech/Language
- Physical Dysfunction
- Emotional/Social
- Behavior

The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. Specify: __________

---

☐ Yes ❑ No  This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child’s ability to participate safely in the program.

☐ Yes ❑ No  Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

☐ The child may fully participate in the program.

☐ The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider | MD/DO | Name (Please type or print.) | Phone number |
---|---|---|---|
Address: | | | |

☐ Yes ❑ No  Is this the child’s Medical Home? | Next Appointment (mm/yy): | Next Immunization Appointment (mm/yy):
CONNECTICUT OFFICE OF EARLY CHILDHOOD
APPROVED FIRST AID COURSES FOR CHILD DAY CARE – November 2020

***Please Note: The course you register for must be an approved course as listed below. Courses must include at least 6 hours of face-to-face instruction (which may be by video) and must include a hands-on demonstration of your ability to provide first aid. Upon completion of the course, the certificate issued must reflect the exact course name as listed below or it will not be accepted.

NATIONWIDE COURSE PROVIDERS

<table>
<thead>
<tr>
<th>TOWN</th>
<th>ASSOCIATIONS</th>
<th>COURSE NAME</th>
<th>WEB ADDRESS</th>
<th>PHONE / CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide</td>
<td>American Heart Association</td>
<td>Heartsaver Pediatric First Aid CPR AED with supplementary materials</td>
<td><a href="http://www.americanheart.org/presenter.jhtml?idIdentifier=3011764">www.americanheart.org/presenter.jhtml?idIdentifier=3011764</a></td>
<td>1-888-277-5463</td>
</tr>
<tr>
<td>Nationwide</td>
<td>American Red Cross</td>
<td>Connecticut Child Care (specify this course)</td>
<td><a href="http://www.ctredcross.org">www.ctredcross.org</a></td>
<td>1-800-733-2767</td>
</tr>
<tr>
<td>Nationwide</td>
<td>American Safety &amp; Health Inst.</td>
<td>ASHI Pediatric CPR, AED, and First Aid</td>
<td>HIS.com</td>
<td>1-800-682-5067</td>
</tr>
<tr>
<td>Nationwide</td>
<td>Health and Safety Institute for</td>
<td>Medic First Aid Pediatric Plus CPR, AED, and First Aid for children, infants, and adults (available in Spanish)</td>
<td>HSI.com</td>
<td>1-800-800-7099</td>
</tr>
<tr>
<td>Nationwide</td>
<td>National Safety Council</td>
<td>NSC Pediatric First Aid Plus</td>
<td><a href="http://www.nsc.org/safety-training/first-aid/courses">www.nsc.org/safety-training/first-aid/courses</a></td>
<td>630-775-2336</td>
</tr>
</tbody>
</table>

OTHER APPROVED COURSES

<table>
<thead>
<tr>
<th>TOWN</th>
<th>PROGRAM</th>
<th>COURSE NAME</th>
<th>E-MAIL ADDRESS</th>
<th>PHONE / CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry</td>
<td>First Aid Training for CT Child Care</td>
<td>First Aid Training for CT Child Care</td>
<td><a href="https://firstaidct.webs.com/">https://firstaidct.webs.com/</a></td>
<td>860-836-5019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Stephanie Knutson</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td><a href="mailto:goldknut@yahoo.com">goldknut@yahoo.com</a></td>
</tr>
<tr>
<td>Guilford</td>
<td>VNA Community Health Care, Inc</td>
<td>First Aid Course for Day Care Providers</td>
<td><a href="mailto:bethccnc@gmail.com">bethccnc@gmail.com</a></td>
<td>203-533-9109</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Laurie Weinberg-Rockwell, R.N.</td>
</tr>
<tr>
<td>Guilford</td>
<td>Community Nurse Consultant Services</td>
<td>First Aid for Child Care Providers</td>
<td><a href="mailto:bethccnc@gmail.com">bethccnc@gmail.com</a></td>
<td>203-533-9109</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Beth Capobianco, RN</td>
</tr>
<tr>
<td>Hartford / Revere, MA</td>
<td>Pro Health Care Services, Inc.</td>
<td>First Aid and Safety for Infants and Children (available in Spanish)</td>
<td><a href="mailto:ggalindo54@hotmail.com">ggalindo54@hotmail.com</a></td>
<td>617-233-6573</td>
</tr>
<tr>
<td>Manchester</td>
<td>Manchester CPR Programs</td>
<td>First Aid for Child Care Providers &amp; Parents</td>
<td><a href="mailto:manchestercpr@gmail.com">manchestercpr@gmail.com</a></td>
<td>860-474-3734</td>
</tr>
<tr>
<td>North Granby/</td>
<td>Nurse Consultants, LLC</td>
<td>First Aid for Child Care Providers</td>
<td><a href="mailto:info@nurseconsultantsllc.com">info@nurseconsultantsllc.com</a></td>
<td>860-500-9042</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Robin Young-Coumoyer</td>
</tr>
<tr>
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<td>PROGRAM</td>
<td>COURSE NAME</td>
<td>E-MAIL ADDRESS</td>
<td>PHONE / CONTACT</td>
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<tr>
<td>Vernon</td>
<td>Eastern CT Health Network</td>
<td>First Aid For Parents &amp; Child Care Providers</td>
<td><a href="mailto:ecrayton@ecn.org">ecrayton@ecn.org</a></td>
<td>860-647-4790 Elizabeth Crayton</td>
</tr>
<tr>
<td>Wolcott</td>
<td>Heartbeats</td>
<td>First Aid for Day Care Providers</td>
<td><a href="mailto:sheliaRN1@sbcglobal.net">sheliaRN1@sbcglobal.net</a></td>
<td>203-910-2886 Sheila Kane</td>
</tr>
<tr>
<td>Woodbridge</td>
<td>Capasso, Renee A.</td>
<td>First Aid for Day Care Providers</td>
<td></td>
<td>203-387-6260 Renee Capasso</td>
</tr>
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</table>
Foster Care or Adoption License Verification

Important: If you answered “yes” to question # 9 on the application, you are required to have this form completed.

Section 1: This section must be completed by the applicant and forwarded to the respective Foster Care Licensing Agency.

Applicant’s Name: ________________________________

Address: ______________________________________________

Town, State, Zip Code: ______________________________

Telephone #: (_______) ____________________________

Section 2: This section below must be completed by the Foster Care Licensing Agency.

The above named person is seeking licensure as a family child care home provider or is applying to be a staff person working at a licensed family child care home and has indicated that he/she has applied for, held, or currently holds a Foster Care License. Please provide the Office of Early Childhood (OEC), Division of Licensing, with the information below.

1. Has the person listed above ever applied for or held a Foster Care or Adoption license?

☐ Yes ☐ No If yes, please provide the OEC with the licensing status and the number of foster children the person is licensed to care for. ___________________

Please provide the OEC with any concerns or recommendations you have concerning the impact of foster care on the provision of child care services in this person’s home.

_________________________________________________________________________________

_________________________________________________________________________________

Once you have completed this form, please return it to the Connecticut Office of Early Childhood, Licensing Division - Application Unit. Should you have any questions or concerns regarding the completion of this form, you may contact the Licensing Division directly using the contact information below.

_________________________________________________________________________________

_________________________________________________________________________________

Date: ________  Name (please print) __________________ Signature __________________

(_______) __________________ Telephone #

____________________________________________________

Title
**REQUEST FOR REFERENCE**

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Please answer the following questions:

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   How well do you know the applicant? ___________________________________________

2. Is the applicant physically and emotionally capable of providing responsible child care?
   COMMENTS: ________________________

3. Is the applicant able to provide reliable and consistent child care?
   COMMENTS: ________________________

4. Is the applicant able to provide adequate and nutritious meals and snacks?
   COMMENTS: ________________________

5. Is the applicant able to deal with emergencies in a calm manner?
   COMMENTS: ________________________

6. Have you observed this person handling children’s problem behaviors? How were the children treated?
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