

# Fairfax County Child Care Central Website Application

Rev: 01/03/14

## CENTER INFORMATION

\_\_\_\_\_ RENEWAL

Check if new address, phone number or contact person \_\_\_\_\_

Center Name \_\_\_\_\_ Tax ID Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State VA Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Website Address: \_\_\_\_\_

Director \_\_\_\_\_ Contact Person \_\_\_\_\_

### **Regulation** Which category applies to your program?

\_\_\_ State License (Dates) from \_\_\_\_\_ to \_\_\_\_\_ \_\_\_ Religious Exemption \_\_\_ Certified Preschool

### **Accreditation**

Is your program accredited by the National Association for the Education of Young Children? \_\_\_ Yes \_\_\_ No

Other accreditation(s) \_\_\_\_\_

### **Affiliation** Is your program affiliated with any outside organizations? \_\_\_ Yes \_\_\_ No

If yes, please list all that apply.

\_\_\_ College \_\_\_ Community-based \_\_\_ Employer-sponsored \_\_\_ Faith-Based \_\_\_ For Profit \_\_\_ Independent

\_\_\_ Local Chain \_\_\_ National Chain \_\_\_ Non-Profit \_\_\_ Private School \_\_\_ Public Agency \_\_\_ Public School

Does your program participate with the USDA Food Program? \_\_\_ Yes \_\_\_ No

### **Environment**

Is your center near public transportation? \_\_\_ Yes \_\_\_ No Is your center wheelchair accessible? \_\_\_ Yes \_\_\_ No

### **Program Enhancements:** List the types of programs your center provides (Check all that apply)

\_\_\_ Parent Co-op \_\_\_ Early Intervention \_\_\_ Head Start \_\_\_ Infant/Toddler only \_\_\_ Kindergarten/Pre-K  
\_\_\_ Mixed Age \_\_\_ Parents Day Out \_\_\_ Preschool \_\_\_ Private School \_\_\_ School Age only  
\_\_\_ School-based \_\_\_ Summer \_\_\_ Other (please specify) \_\_\_\_\_

### **CHILD CARE COSTS WILL NOT APPEAR ON THE WEB SITE**

REGISTRATION FEE \$ \_\_\_\_\_ One-time \_\_\_ Yearly

### **Monthly Child Care Rates:**

Check all ages you serve and fill in rates:

___ Infants (birth - 15 months) \$ _____	___ Preschool Age Four (48 – 59 months) \$ _____
___ Toddler (16 - 23 months) \$ _____	___ Preschool Age Five (Before School Age) \$ _____
___ Preschool Age Two (24 – 35 months) \$ _____	___ School Age: Full Day \$ _____
___ Preschool Age Three (36 – 47 months) \$ _____	___ School Age: Before and After School \$ _____

**Schedule** (hours and days of operation as well as alternative schedules you offer)

**Hours of Operation:** Open \_\_\_\_\_ a.m. Close \_\_\_\_\_ p.m.

**Schedule Options:** \_\_\_ Full-time \_\_\_ Part-time

**Days of Operation:** \_\_\_ Sun \_\_\_ Mon \_\_\_ Tues \_\_\_ Wed \_\_\_ Thurs \_\_\_ Fri \_\_\_ Sat

**Care Level and Options**

Minimum Age you would enroll \_\_\_\_\_ mos/yrs Maximum Age you would enroll \_\_\_\_\_ mos/yrs

**Alternative Options you are willing to consider:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> before school          | <input type="checkbox"/> year round          | <input type="checkbox"/> evening care      |
| <input type="checkbox"/> after school           | <input type="checkbox"/> extended hours      | <input type="checkbox"/> weekend care      |
| <input type="checkbox"/> before/after preschool | <input type="checkbox"/> occasional/back-up  | <input type="checkbox"/> summer only       |
| <input type="checkbox"/> holidays/vacation      | <input type="checkbox"/> shift/rotating week | <input type="checkbox"/> before/after camp |
| <input type="checkbox"/> school year only       | <input type="checkbox"/> morning             | <input type="checkbox"/> 24-hour           |

**Special Services**

**Experience or training in the care of children with special needs** \_\_\_ Yes \_\_\_ No

**Check if you have staff with experience or training to provide the following types of special care**

**(Please check where appropriate):**

- |   |   |
|---|---|
| <input type="checkbox"/> Adaptive/special equipment<br>(apnea monitor, catheter, g-tube, nebulizer) | <input type="checkbox"/> Down's Syndrome  |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Emotional/learning disabilities (ADHD/ADD, autism, challenging behaviors)    |
| <input type="checkbox"/> Asthma/respiratory conditions  | <input type="checkbox"/> Physical Impairments (hearing impaired, motor impairment, visually impaired) |
| <input type="checkbox"/> Cerebral Palsy, neurological or seizure disorder                           | <input type="checkbox"/> Physical or occupational therapy   |
| <input type="checkbox"/> Development delay (language/speech delay)                                  | <input type="checkbox"/> Special diets  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Other (please specify) _____   |
| <input type="checkbox"/> Dispense Medication  |   |

**Language** Please list the languages spoken by your staff:

- |                                  |                                  |                                      |
|----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Punjabi | <input type="checkbox"/> French      |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Farsi   | <input type="checkbox"/> Vietnamese  |
| <input type="checkbox"/> Hindi   | <input type="checkbox"/> Arabic  | <input type="checkbox"/> Tagalog     |
| <input type="checkbox"/> Urdu    | <input type="checkbox"/> Bengali | <input type="checkbox"/> Other _____ |

Can anyone in your program use sign language? \_\_\_ Yes \_\_\_ No

**Transportation** Do you transport children to/from their home to your care? \_\_\_ Yes \_\_\_ No

List the elementary school(s) you are near and whether transportation is available to and/or from the school(s) and your program. The transportation can be either by school bus or your program vehicle.

- |                   |               |                 |
|-------------------|---------------|-----------------|
| School Name _____ | ___ to school | ___ from school |
| School Name _____ | ___ to school | ___ from school |
| School Name _____ | ___ to school | ___ from school |

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

By signing this application to become part of the Child Care Central Database, I understand that information about my program will be made available to the public through the Office for Children's Child Care Central Website and on listings requested by parents. I also understand that the Office for Children reserves the right to remove a child care program from the Child Care Central Database.

Please call Community Education and Provider Services at (703) 324-8100 with any questions. [www.fairfaxcounty.gov/ofc](http://www.fairfaxcounty.gov/ofc)

**FAIRFAX COUNTY OFFICE FOR CHILDREN**  
12011 Government Center Parkway, 8<sup>th</sup> Floor Suite 820  
Fairfax, VA 22035-1104  
Fax: (703) 653-1302

**For Office Use Only**

**CCMS #** \_\_\_\_\_

**Map Code** \_\_\_\_\_

**Application Received** \_\_\_\_\_

**Date entered into CCMS** \_\_\_\_\_