

Fairfax County Child Care Central Website Application

PROVIDER INFORMATION

_____ RENEWAL

Check if new address or phone number _____

Name _____ Business or Tax ID # _____
(If Applicable)

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Alternate Phone # _____ Fax # _____

e-mail Address: _____ Website Address: _____

Which category of regulation applies to your family child care home?

County Permit Fairfax City Ft. Belvoir State License (Dates) from _____ to _____
 Falls Church City Infant/Toddler Family Child Care System

Accreditations

_____ NAFCC _____ CDA _____ Expiration Date
National Association of Family Child Care *Child Development Associate Credential*

Do you have Pets? Yes No If yes, Indoors Outdoors only

Do you provide a smoke free (no one in the home is a smoker) environment? Yes No

Is your home: Near public transportation ? Wheelchair accessible ?

USDA Food Program Participation

_____ OFC USDA Food Program Other USDA Food Program _____ none

List your neighborhood elementary school

School Name (base school) _____

CHILD CARE COSTS WILL NOT APPEAR ON THE WEB SITE

REGISTRATION FEE \$ _____ One-time Yearly

FEES

Check all ages you serve:

Weekly Child Care Rates:

<input type="checkbox"/> Infants (birth - 15 months)	\$ _____	<input type="checkbox"/> Kindergarten (60 – 71 months)	\$ _____ full day
<input type="checkbox"/> Toddler (16 - 23 months)	\$ _____	<input type="checkbox"/> before and after kindergarten	\$ _____
<input type="checkbox"/> Two-year old (24 – 35 months)	\$ _____	<input type="checkbox"/> School age (72 months – 13 years)	\$ _____ full day
<input type="checkbox"/> Young Preschool (36 – 47 months)	\$ _____	<input type="checkbox"/> before and after school	\$ _____
<input type="checkbox"/> Older Preschool (48 – 59 months)	\$ _____		

Care Level

Schedule Hours and days of operation as well as alternative schedules you offer

Hours of Operation: Open _____ a.m. Close _____ p.m.

Minimum age you would enroll _____ mos/yrs Maximum age you would enroll _____ mos/yrs

Schedule Options: ___ Full-time only ___ Full-time and Part-time ___ Part-time only

Days of Operation: ___ Sun ___ Mon ___ Tues ___ Wed ___ Thur ___ Fri ___ Sat

Alternative Options you are willing to consider:

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

Describe any other schedule options you offer: _____

SPECIAL SERVICES

Experience or training in the care of children with special needs ___ Yes ___ No

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

(please circle where appropriate):

- | | |
|---|--|
| <input type="checkbox"/> Adaptive/special equipment | <input type="checkbox"/> Dispense Medication |
| <input type="checkbox"/> Catheter, g-tube | <input type="checkbox"/> Downs Syndrome |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional/learning disabilities,
___ ADHD/ADD, challenging behaviors |
| <input type="checkbox"/> Apnea monitor | <input type="checkbox"/> Nebulizer |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Physical Impairments (hearing impaired, motor
impairment, visually impaired) |
| <input type="checkbox"/> Asthma/respiratory conditions | <input type="checkbox"/> Physical or occupational therapy |
| <input type="checkbox"/> Cerebral Palsy, neurological or seizure disorder | <input type="checkbox"/> Special diets |
| <input type="checkbox"/> Development delay (language/speech delay) | |
| <input type="checkbox"/> Diabetes | |

Are you willing to provide care for mildly ill children? (colds, ear infection, fever, etc.) ___ Yes ___ No

Language: Please list the languages you speak: ___ English ___ Spanish ___ Vietnamese
___ Farsi ___ Korean ___ Hindi ___ Punjabi Other (please specify) _____

Can you use sign language? ___ Yes ___ No

Do you transport children?

Other School _____ **To School** _____ **From School** _____
___ from their home to your care? ___ Yes ___ No
___ from your care to their home? ___ Yes ___ No

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/childcare

FAIRFAX COUNTY OFFICE FOR CHILDREN
12011 Government Center Parkway, 8th Floor Suite 820
Fairfax, VA 22035-1104
Fax: (703) 324-3925

For Office Use Only

CCMS # _____ Map Code _____
Application Received _____ Date entered into CCMS _____