STATE OF CONNECTICUT

Connecticut Office of Early Childhood

TO: Family Child Care Home Applicants

FROM: Licensing Division

Thank-you for your interest in Family Child Care Home licensing. The **Initial Application** for licensure is designed to meet the requirements of the Regulations for Connecticut State Agencies for Family Child Care Homes, Sections **19a-87b-1 through 19a-87b-18**, inclusive. **Please retain one copy of the completed application for your own records.**

The Initial Application for the licensure packet consists of:

1. Coordinating Check List

2. Initial Application Fee Form - Make your check payable to "Treasurer State of Connecticut". **This fee is not refundable**

3. Initial Application for Licensure – be sure to answer all the questions completely, including signing the attestation that you have read and understand the Regulations.

4. Foster Care or Adoption Verification Form

5. Adult Medical Statement for Child Care

6. CT Early Childhood Health Assessment Record (for children ages birth to 5) or Health Assessment Record (for school age children)

7. References

8. Lead Water Test

9. Background checks are required for each household member 18 years of age or older. To complete your background checks, please visit the website at https://resources.211childcare.org/backgroundcheck/ and choose the provider type that applies to you. If you have questions regarding the background check process, please contact the Background Check Information System (BCIS) at https://helpdesk.oecit.org/

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. Note: We cannot schedule an inspection of your home until your application is complete.

Please read and be familiar with the Regulations before your appointment. You can access them online at: www.ct.gov/oec or call 800-282-6063 to request a copy in the mail. In addition, please view our on-line videos titled; **How to Become a Licensed Family Child Care Provider and Maintaining Compliance: Family Child Care Homes.** These video will provide you with valuable information.

Phone: (860) 500-4450 · Fax: (860) 326-0552
450 Columbus Boulevard, Suite 302
Hartford, Connecticut 06103
www.ct.gov/oec

Coordinating Check List for Initial Family Child Care Home Application

Provider Name _____ Town _____

- ☐ **Application**
- ☐ **Application Fee**
- ☐ **Application Fee Form**
- ☐ **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.
- ☐ **Adult Medical Statement for Child Care -** for each household members 18 years of age or older. Physical examination must have been within the past year.
- ☐ **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.
- ☐ **References -** submit three Request for Reference Forms that are complete, current and signed by individuals (no more than one relative) who have known you for at least three years.
- ☐ **Certificate for Approved First Aid Training -** a copy of a certificate documenting current certification by the American Red Cross, the American Heart Association, the National Safety Council, American Safety and Health Institute, or Medic First Aid International, Inc. or a current certification based on a first aid course approved on or before March 17, 2018 by the Office.
- ☐ **Certificates for Approved CPR Training -** a copy of a certificate documenting current certification in CPR appropriate for all of the children to be served at the family child care home.
- ☐ **Background Checks** ☐ **State & Federal Fingerprint Cards** ☐ **DCF**
- ☐ **Lead water test -** a lead water test conducted no more than twelve months prior to the date of this application, analyzed by a state certified laboratory (found at this website: https://portal.ct.gov/DPH/Environmental-Health/Environmental-Laboratory-Certification/Environmental-Laboratory-Certification) from a sink used for drinking, beverage and food prep. The water shall have been standing in plumbing pipes at least six hours (Section 19a-87b-9i).
- ☐ **Well (Bacteria and Chemical) Water Test -** 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.
- ☐ **Auxiliary heating device Inspection Report** - if you have auxiliary heating (i.e., wood stove, pellet stove, gas insert), it must be inspected and approved for proper and safe installation.

STATE OF CONNECTICUT

Connecticut Office of Early Childhood

Initial Application Fee Form

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:

   _____, _____ _____
   Street Address ***City/Town*** ***Zip Code***

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

5. Mailing Address (if different):

   _____ _____, CT _____
   Street Address ***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)*

Child Care Center (Account #42431)	**Group Care Home** (Account #42431)	**Family Care Home** (Account #42431)
☐ 4-year license (new program) **$500.00**	☐ 4-year license (new program) **$250.00**	☐ 4-year license (new provider) **$40.00**

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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. **What is your primary language?** _____

8. ☐ **Yes** ☐ **No** **Have you ever applied for or held a child day care license in Connecticut or in any other state? If yes:**

   When and where (what address)?_____

   License # _____

   Licensing Agency Name: _____

   Licensing Agency contact information (Address, Telephone number, email): _____

   _____

   _____

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?**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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 fifteen (15) 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):

Full Name	Relation to You	Date of Birth	Times Present in the Home per Day (Please be very specific)

16. ☐ **Yes** ☐ **No** **Do you, or 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 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.

Name	Complete Mailing Address Including Zip Code	Telephone #	Expiration Date
		( )	
		( )	
		( )	

19. ☐ **Yes** ☐ **No** **Was the residence in which you will be providing child care constructed before 1978? (Please check The Town Assessor's Office website or with your Town Building Department if you or the homeowner do not know this information)**

PLEASE NOTE: Samples of peeling paint chips will be collected for lead testing at the time of your initial inspection if the building was constructed before 1978.

20. ☐ **Yes** ☐ **No** **Is the residence in which you will be providing child care designated as a multi-family home by the Town? If so, how many dwelling units (apartments) are there? _____**

21. ☐ **Yes** ☐ **No** **Does the home have an auxiliary heating device, i.e., wood stove, pellet stove, gas insert? 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.**

22. ☐ **Yes** ☐ **No** **Is the home served by a private well?**
If yes, you must also submit water tests (conducted no more than twelve months prior to the date of this application) for bacteria, physical parameters and sanitary chemicals (analyzed by a state certified laboratory). The water supply must be deemed potable, adequate and safe.

☐ **Yes** ☐ **No** **Water test enclosed.**

23. ☐ **Yes** ☐ **No** **Is there 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?**

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 am familiar with, have read and understand sections 19a-87b-1 to 19a-87b-18, inclusive, of the Regulations of Connecticut State Agencies, and that I agree to abide by them.

I shall allow the Office immediate access during customary business hours to the facility whenever the Office seeks to perform an inspection. I understand that failure to allow immediate access during customary business hours to the entire facility is deemed substantial noncompliance and is an automatic ground for the commissioner to initiate license suspension or revocation proceedings.

I certify that all children enrolled in the family child care home are up-to-date on immunizations or otherwise exempt under Section 19a-87b-10(l) of the Regulations of Connecticut State Agencies for the licensure of family child care homes.

NOTICE OF PENALTY FOR FALSE STATEMENTS

I understand that all information provided on this application form, or in any statements accompanying this application, must be truthful. Any false statements made herein are punishable in accordance with Section 53a-157b of the Connecticut General Statutes and may also be grounds for the denial of the license.

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)***

_____
(Printed Name)

CONNECTICUT OFFICE OF EARLY CHILDHOOD

DIVISION OF LICENSING

ADULT MEDICAL STATEMENT for CHILD CARE

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 Care Center Employee

☐ Adult Member of Household

Patient's Name _____ Phone # _____ Date of Birth ___/___/___

Street Address _____ Town _____ Zip Code _____

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

This medical clearance is an important requirement in child care licensing laws designed to protect the health, safety and welfare of the children in day 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: (upon employment or initial application for Child Care Center and Group Child Care Home staff ONLY)
   Tuberculin skin test Date _____ ☐ Positive ☐ Negative
   or Chest x-ray Date _____ ☐ Positive ☐ Negative

4. Medical Provider's Information
   Name: _____
   Address: _____
   Phone #: _____

5. _____ / _____
   Signature of MD, APRN or PA Date

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

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex

Address (Street) (Town and ZIP code)	Race/Ethnicity	
	❑ American Indian	❑ White, not of Hispanic origin
	❑ Asian	❑ Hispanic/Latino
	❑ Black, not of Hispanic origin	❑ Other

Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number

Early Childhood Program	Program Phone Number

Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/Number*

* 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

Part II — Health Evaluation

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

Child's Name _____ Birth Date (mm/dd/yy) _____ Date of History/Physical Exam (mm/dd/yy) _____

LENGTH/HEIGHT	WEIGHT	WT FOR HT/BMI	HEAD CIRCUMFERENCE[1]	BLOOD PRESSURE[2]
IN/CM %ILE	LB/KG %ILE	%ILE	IN/CM %ILE	/

Screening/Test Results

Screening Test	Result	Date	Abnormal/Comments
Vision[2] Test type:			
Hearing[3] Test type:			
Lead[4] Risk: Yes/No			
TB[4] Risk: Yes/No			
Urinalysis (UA)[4]			
Anemia[5] (HGB/HCT) Risk: Yes/No			
Developmental Assessment[6] Test type:			

Has this child received dental care in the last 12 months?[7] ❑ **Yes** ❑ **No** ❑ **N/A**

*** Chronic Disease Assessment:**

Yes	No		Date of onset
❑	❑	Asthma: ❑ mild ❑ moderate ❑ severe ❑ exercise induced ❑ unclassified	
❑	❑	Diabetes: ❑ Type I ❑ Type II	
❑	❑	Anaphylaxis: ❑ med. ❑ food ❑ insect ❑ latex	
❑	❑	Seizures: Type _____	
❑	❑	Other: Please specify _____	

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

Immunization Record

Vaccine (Month/Day/Year)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV					Pneumococcal conjugate vaccine	

Other Vaccines (Specify)

Disease Hx of above _____ (Specify) _____ (Date mm/yy) _____ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

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 NP PA	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
FIRST AID COURSES FOR FAMILY CHILD CARE – March 19, 2021

*****Please Note: You must submit verification of current certification in first aid by the American Red Cross, the American Heart Association, the National Safety Council, American Safety and Health Institute, or Medic First Aid International, or a current certification based on a first aid course approved on or before March 17, 2018 by the Connecticut Office of Early Childhood. Courses must include a hands-on demonstration of your ability to provide first aid.**

NATIONWIDE COURSE PROVIDERS

TOWN	ASSOCIATIONS	WEB ADDRESS	PHONE / CONTACT
Nationwide	American Heart Association	www.americanheart.org	1-888-277-5463
Nationwide	American Red Cross	www.ctredcross.org	1-800-733-2767
Nationwide	American Safety & Health Inst.	www.emergencycare.hsi.com	1-800-682-5067
Nationwide	Medic First Aid International, Inc.	www.emergencycare.hsi.com	1-800-800-7099
Nationwide	National Safety Council	www.nsc.org/safety-training/first-aid/courses	630-775-2336

OTHER APPROVED COURSES

TOWN	PROGRAM	COURSE NAME	E-MAIL ADDRESS	PHONE / CONTACT
Coventry	First Aid Training for CT Child Care	**First Aid Training for CT Child Care**	https://firstaidct.webs.com/	860-836-5015 Stephanie Knutson goldKnut@yahoo.com
Guilford	VNA Community Health Care, Inc	**First Aid Course for Day Care Providers**		203-458-4233 Laurie Weinberg-Rockwell, R.N.
Guilford	Community Nurse Consultant Services	**First Aid for Child Care Providers**	bethccnc@gmail.com	203-533-9109 Beth Capobianco, RN
Hartford / Revere, MA	Pro Health Care Services, Inc.	**First Aid and Safety for Infants and Children** ***(available in Spanish)***	ggalindo54@hotmail.com	617-233-6573 Guillermo Galindo
Manchester	Manchester CPR Programs	**First Aid for Child Care Providers & Parents**	manchestercpr@gmail.com	860-474-3734 Dawn Sinclair
North Granby/ Ellington	Nurse Consultants, LLC	**First Aid for Child Care Providers**	info@nurseconsultantsllc.com Website: NurseConsultantsLLC.com	860-500-9042 Robin Young-Cournoyer
Vernon	Eastern CT Health Network	**First Aid For Parents & Child Care Providers**	ecrayton@echn.org	860-647-4790 Elizabeth Crayton
Wolcott	Heartbeats	**First Aid for Day Care Providers**	sheliaRN1@sbcglobal.net	203-910-2886 Sheila Kane
Woodbridge	Capasso, Renee A.	**First Aid for Day Care Providers**		203-387-6260 Renee Capasso

CARDIOPULMONARY RESUSCITATION (CPR) PROVIDERS FOR CHILD CARE PROVIDERS

Section 19a-79 of Connecticut General Statutes, as amended by Public Act 19-105, and:

- Section 19a-79-4a of the Regulations for Connecticut State Agencies require at all times a licensed **child care center** is in operation there shall be present at least one staff member who has current certification in cardiopulmonary resuscitation (CPR). Staff of child care programs that are exempt from licensing but accept Care4Kids shall also meet this requirement; and,
- Section19a-87b-6(c) of the Regulations for Connecticut State Agencies requires that a **family child care home** applicant/provider shall have current certification in cardiopulmonary resuscitation (CPR).

The above certification shall be appropriate for all of the children served in the child care program, shall be based on a hands-on demonstration of the individual's ability to provide CPR and shall be issued by one of the following organizations:

- **American Red Cross**
  Local Chapter 877-287-3327
  Training Support Center 800-Red Cross/800-733-2767
  www.ctredcross.org
  Note - Adult is considered age 12 or older for CPR

- **American Heart Association**
  Local Number 203-294-0088
  National Service Center 877-AHA-4CPR
  www.Americanheart.org
  Note - Adult is considered at the onset of puberty for CPR

- **American Safety & Health Institute**
  1-800-447-3177
  www.emergencycare.hsi.com or customerservice@hsi.com
  Note - Adult is considered at the onset of puberty for CPR

- **Medic First Aid**
  1-800-447-3177
  www.emergencycare.hsi.com or customerservice@hsi.com
  Note - Adult is considered at the onset of puberty for CPR

- **National Safety Council**
  1-800-621-7615 x2336
  www.nsc.org
  Note - Adult is considered at the onset of puberty for CPR

- **An organization using guidelines for CPR and emergency cardiovascular care published by the American Heart Association (AHA) and International Liaison Committee on Resuscitation (ILCOR).** In such cases, there must be written confirmation that the organization follows such guidelines.

STATE OF CONNECTICUT

Connecticut Office of Early Childhood

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

_____ (_____) _____
Title Telephone #

Phone: (860) 500-4450 · Fax: (860) 326-0552
450 Columbus Boulevard, Suite 302
Hartford, Connecticut 06103
www.ct.gov/oec

Connecticut Office of Early Childhood
Division of Licensing
Family Child Care

Return to:
Office of Early Childhood-Family Child Care-Application Unit
450 Columbus Boulevard, Suite 302
Hartford, CT 06103

REQUEST FOR REFERENCE

Regarding the following person:	Who is an applicant for the position of:
name	☐ Main child caregiver in a Family Child Care Home
address	
town, zip state	☐ Substitute or Assistant caregiver in Family Child Care Home

Please answer the following questions:

1	How long have you known the applicant? (What period of time?)_____ In what capacity? (relative? friend? employer? caregiver? neighbor?_____ 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?

7	In your opinion, is the applicant's family stable and harmonious? COMMENTS:	
8	Do you know of any reason that this person should not be caring for children? COMMENTS:	
9	Does the applicant demonstrate good judgment about supervision and safety for children? COMMENTS:	
10	Does the applicant demonstrate an interest and affection for children? COMMENTS:	
11	Does the applicant have a good understanding of individual children's developmental needs? COMMENTS:	
12	Please use this space for your personal comments and observations.	
	Signature:	Printed Name:
	Date:	Street:
	Telephone:	City, State, Zip:

Connecticut Office of Early Childhood
Division of Licensing
Family Child Care

Return to:
Office of Early Childhood-Family Child Care-Application Unit
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Hartford, CT 06103

REQUEST FOR REFERENCE

Regarding the following person:	Who is an applicant for the position of:
name	☐ Main child caregiver in a Family Child Care Home
address	
town, zip state	☐ Substitute or Assistant caregiver in Family Child Care Home

Please answer the following questions:

1	How long have you known the applicant? (What period of time?)_____ In what capacity? (relative? friend? employer? caregiver? neighbor?_____ 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?

7	In your opinion, is the applicant's family stable and harmonious? COMMENTS:	
8	Do you know of any reason that this person should not be caring for children? COMMENTS:	
9	Does the applicant demonstrate good judgment about supervision and safety for children? COMMENTS:	
10	Does the applicant demonstrate an interest and affection for children? COMMENTS:	
11	Does the applicant have a good understanding of individual children's developmental needs? COMMENTS:	
12	Please use this space for your personal comments and observations.	
	Signature:	Printed Name:
	Date:	Street:
	Telephone:	City, State, Zip:

Connecticut Office of Early Childhood
Division of Licensing
Family Child Care

Return to:
Office of Early Childhood-Family Child Care-Application Unit
450 Columbus Boulevard, Suite 302
Hartford, CT 06103

REQUEST FOR REFERENCE

Regarding the following person:	Who is an applicant for the position of:
name	☐ Main child caregiver in a Family Child Care Home
address	
town, zip state	☐ Substitute or Assistant caregiver in Family Child Care Home

Please answer the following questions:

1	How long have you known the applicant? (What period of time?)_____ In what capacity? (relative? friend? employer? caregiver? neighbor?_____ 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?

7	In your opinion, is the applicant's family stable and harmonious? COMMENTS:	
8	Do you know of any reason that this person should not be caring for children? COMMENTS:	
9	Does the applicant demonstrate good judgment about supervision and safety for children? COMMENTS:	
10	Does the applicant demonstrate an interest and affection for children? COMMENTS:	
11	Does the applicant have a good understanding of individual children's developmental needs? COMMENTS:	
12	Please use this space for your personal comments and observations.	
	Signature:	Printed Name:
	Date:	Street:
	Telephone:	City, State, Zip: