

WASHINGTON COUNTY
DEPARTMENT OF JOB AND FAMILY SERVICES

P. O. BOX 2005
1115 GILMAN AVENUE
MARIETTA, OHIO 45750

Phone: (740) 373-5513
Fax: (740) 373-9790

Name: _____

Date: _____

In order for us to help with your initial certification or continuing certification as a Type B Family Child Care provider or an In-Home Child Care provider, the items marked below must be completed & returned.

- _____ A completed medical evaluation (ODHS 1280).
- _____ Completed emergency plan. (AF-680)
- _____ You and each person over age 18 will need to read and sign one of the attached non-conviction statement (JFS 1329).
- _____ You will need to select two emergency care givers and they must complete and sign a release to Children Services (ODHS 1302).
- _____ Each emergency care giver will need to sign a non-conviction statement (ODHS 1329).
- _____ A Child Medical Statement (JFS 1932) will be needed, on your child, if they are not attending school.
- _____ List of previous child care experience. (AF-678)
- _____ We need the name, mailing address, and phone number of three individuals for references (non-relatives).
- _____ Verification of your pet(s) vaccinations and license.
- _____ Water test results, if not using a city water source.
- _____ Copy of a valid driver's license and auto insurance.
- _____ Copy of your high school diploma or GED equivalent.
- _____ You and each adult household member must be fingerprinted. (form will be given at interview)
- _____ Each emergency care giver must be fingerprinted.
- _____ Please call 740-373-5513 to schedule an appointment time for the required interview/home inspection.
- _____ Other: **CPR, First Aid , Health & Safety in Family Day Care trainings for provider and emergency caregivers.**

If you fail to furnish the above items to our agency by _____, it may result in the denial of your child care provider application. If you have any questions, please feel free to contact our office at 740-373-5513.

Sincerely,

Social Service Worker

approved by:

Kelly Bauerbach

AF-677
8/08

Ohio Department of Job and Family Services
APPLICATION FOR PROFESSIONAL TYPE B HOME AND IN-HOME AIDE CERTIFICATION

Section I To Be Completed by County Agency		Submit this Application to (<i>County Agency Name and Address</i>):
Telephone Number		
Name of County Child Care Contact		
Status of Application:		
<input type="checkbox"/> Date Application Submitted	<input type="checkbox"/> Date BCII/FBI Checks Submitted <input type="checkbox"/> Date BCII Results Received <input type="checkbox"/> Date FBI Results Received	<input type="checkbox"/> Date Provider Agreement Completed
<input type="checkbox"/> Date PCSA Request Submitted	<input type="checkbox"/> Date PCSA Results Received	
<input type="checkbox"/> Date Initial Inspection Completed	<input type="checkbox"/> Date Certificate Issued	<input type="checkbox"/> Date Application Denied

The information in Section II through Section V will give us an idea of the types of services you may be able to provide. However, your answers to these questions will not be taken as a final commitment. The county agency worker will discuss this information with you.

Section II - General Information			
Name of Applicant	Birth Date	Social Security Number	E-Mail Address (<i>required</i>)
Address	Previous Last Names of Applicant		Telephone Number
City, State, and Zip Code		What is your educational level?	
Which children are you willing to care for? <input type="checkbox"/> Infants (0-18 months) <input type="checkbox"/> Toddlers (18-36 months) <input type="checkbox"/> Preschool children <input type="checkbox"/> School children <input type="checkbox"/> Children with special needs When do you prefer to care for children? <input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends <input type="checkbox"/> Overnight		<input type="checkbox"/> High School Graduate Date _____	
		<input type="checkbox"/> GED Diploma Date _____	
		<input type="checkbox"/> College Graduate Date _____	
		How many of your own children are under the age of six?	
		How many children other than your own are you caring for at this time?	
		List their ages:	

Are you presently employed inside or outside your own home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the chart below.			
Name of Employer		City	
Address		State	Zip Code
Position	Day Working	Time of Work	Hours Worked Per Day
	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sat		
	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sat		
	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sat		
	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sat		

Are you currently receiving OWF benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a foster parent? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a specialized care foster home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you caring for foster children at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list their names

Name of foster care worker(s) and agency(ies)

Have you previously been certified or are you currently certified as a child care provider by any county Department of Job and Family Services? Yes No If yes, please list

Do you have a swimming pool or open body of water 2 feet or deeper at your residence?
 Yes No

Section III - Training and Experience

Have you had any formal training in child care? Yes No If yes, complete this chart

Year Completed	Name of Course	Certificate, Diploma or Credential Received

Summarize your previous experience in caring for children and/or in child care-related employment and indicate the length of the experience.

Section IV - List the people living in your home, including children, foster children, relatives and boarders.

First and Last Name	Social Security Number	Birth Date	Relationship to Applicant

Please show that you have or are willing to provide the following:

Evidence of physical examination as required by certification rules	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A working land line telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A complete first aid kit	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A working smoke detector and carbon monoxide detector in the basement and on each level	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A stove or microwave and refrigerator in working order	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Meals and snacks for the children receiving care	<input type="checkbox"/> Yes	<input type="checkbox"/> No

A separate crib for each infant receiving care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A bed, sofa, cot, pad or mat for each toddler, preschooler or school age child who rests	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Evidence of laboratory approval of your water supply (for nonpublic water systems only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DATE _____		
An approved, portable fire extinguisher	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Childproof protective covers for electrical outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A smoke-free environment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Information necessary to perform a BCII and an FBI criminal records check on you, other adult residents in your home and emergency/substitute caregivers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Information necessary for the PCSA to conduct an abuse or neglect registry search on you and other adult residents in your home	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section VI - References

If you do not have at least three child care or employer references, list three references from persons **who are not related to you** who can speak to your ability to care for children. The county agency cannot approve your application without first contacting your references. The county agency may contact references by mail, therefore you must show complete names and addresses below.

Name of Reference		Name of Reference		Name of Reference	
Address		Address		Address	
City		City		City	
State	State	State	State	State	Zip Code
Telephone Number		Telephone Number		Telephone Number	

- I am physically, intellectually and emotionally capable of complying with Chapter 5101:2-14 of the Ohio Administrative Code and can perform all activities related to child care.
 - I agree to complete the required documents by logging onto the ODJFS Provider Portal at: <http://jfs.ohio.gov/cdc/childcare.stm>
 - I understand that the submission of these documents through the Provider Portal must be completed before I provide any publicly funded child care services and that these forms are necessary in order for ODJFS to reimburse me for providing publicly funded child care services in my home.
 - I understand that approval of this application is based on the information I have provided and information obtained during a home inspection. Any false or misleading statements made on this application may be grounds for denial of my application. To the best of my knowledge the information I have given is true and correct.
- My signature below means that I have read and agree to the terms of this application.**

Signature of Applicant	Date
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This form is used to meet the requirements of chapter 5101:2-14 of the Administrative Code.

Ohio Department of Job and Family Services
**MEDICAL STATEMENT FOR TYPE B HOME
 AND IN-HOME AIDE CHILD CARE PROVIDERS**

To the physician, physician's assistant (PA), advanced practice nurse (APN), certified nurse midwife (CNM) or certified nurse practitioner (CNP): The completion of the form is required before this applicant can be certified as an in-home provider for child care services. Child care services includes the full time or part time care of up to six children ages birth to thirteen years.

All sections of this form must be completed.

Name of Child Care Provider	Date of Birth	
Street Address		
City	State	Zip Code
Date of Exam		

This is to certify that I have examined the above named person who I have found:

Yes No Is free from communicable disease.

Yes No Has been immunized against measles and mumps, or was born before December 31, 1956 and has a disease history of measles and mumps, or is exempt from this requirement for medical or religious reasons. If exempt, please explain:

Yes No Has been immunized against rubella, or has a laboratory test demonstrating detectable rubella antibodies, or is exempt from this requirement for medical or religious reasons. If exempt, please explain:

Yes No Is free from tuberculosis as verified by a current TB test: _____ (date).

Yes No Has been immunized against Tetanus and Diphtheria or is exempt from this requirement for medical or religious reasons. (At the time the next booster for Tetanus and Diphtheria is due, the provider or in-home aide must also be immunized against Pertussis.) (Tdap) If exempt, please explain:

Yes No Is free from any known physical or mental health problems which might interfere with the safety or health of children, or might prohibit this individual from providing adequate care for a group of young children in a home setting. If not, please explain:

Printed name of Physician, PA, APN, CNM or CNP	Telephone Number	
Street Address		
City	State	Zip Code
Signature of the examining Physician, PA, APN, CNM or CNP		

This prescribed form is used to meet the requirements of Chapter 5101:2-14 of the Ohio Administrative Code.

Emergency plan

Providers name: _____

Date: _____

1. The following emergency numbers are located on or near the telephone.
 - a. Poison Control 1-800-682-7625
 - b. Fire department _____
 - c. Life squad/hospital _____
 - d. Sheriff/police _____
 - e. Children Service Bd. 373-3485

2. Give location of the following:
 - A. Parent/Provider forms & Emergency Transportation forms. _____
 - B. Children's medical forms _____
 - C. First aid kit _____
 - D. First aid manual _____
 - E. Flashlight _____

3. How will transportation be provided in an emergency? _____

4. What is the procedure for evacuation in case of fire? (Be sure to include provision for the children who may have to be carried.) _____

5. Draw a general floor plan of home: you will need to indicate escape routes and meeting places on the plan. Use the other side of this sheet if necessary.