

**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: _____

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

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 (County Agency Name and Address):
Telephone Number		
Name of County Child Care Contact		
Status of Application:		
<input type="checkbox"/> Application Submitted (date)	<input type="checkbox"/> BCII/FBI Checks Submitted (date)	BCII Results Received (date) FBI Results Received (date)
<input type="checkbox"/> PCSA Request Submitted (date)		<input type="checkbox"/> PCSA Results Received (date)
<input type="checkbox"/> Initial Inspection Completed (date)	<input type="checkbox"/> Certificate Issued (date)	<input type="checkbox"/> Application Denied (date)

The following 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 agency worker will discuss these items further with you.

Section II: General Information		
Name of Applicant	Birth Date	Social Security Number
Address	Previous Last Names of Applicant	Telephone Number of Applicant
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	High School Graduate <input type="checkbox"/> Date: _____ GED Diploma <input type="checkbox"/> Date: _____ College Graduate <input type="checkbox"/> 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:		

List your usual and customary charge to the public. (This is the price you would charge if providing this service to a private pay customer.)

	Infant	Toddler	Pre School	School Age	School Age Summer
Weekly Full Time (25 to 50 hours)	\$	\$	\$	\$	\$
Weekly Part Time (7 to 24.9 hours)					
Daily Full Time (5 to 12 hours)					
Daily Part Time (less than 5 hours)					
Hourly					
Other (registration, transportation, activity fee, absent days)					

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

- Evidence of physical examination as required by certification rules Yes No
- A working land line telephone Yes No
- A complete first aid kit Yes No
- A working smoke detector and carbon monoxide detector in the basement and on each level Yes No
- A stove or microwave and refrigerator in working order Yes No
- Meals and snacks for the children receiving care Yes No
- A separate crib for each infant receiving care Yes No
- A bed, sofa, cot, pad or mat for each toddler, preschooler or schoolage child who rests Yes No
- Evidence of laboratory approval of your water supply (for nonpublic water systems only) Yes No DATE _____
- An approved, portable fire extinguisher Yes No
- Childproof protective covers for electrical outlets Yes No
- A smoke-free environment Yes 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 Yes No
- Information necessary for the PCSA to conduct an abuse or neglect registry search on you and other adult residents in your home Yes No

Section VI: References

If you do not have at least three child care or employer references, list three references from persons unrelated 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 complete names and addresses are necessary.

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

- I verify that I am physically, intellectually, and emotionally capable of complying with Chapter 5101:2-14 of the Ohio Administrative Code and performing activities normally related to child care.
- I understand that approval is based on the information I provide in this application and 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 abide by the terms of this agreement.

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.
Distribution: Original to agency, copy to provider

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.

Emergency plan

Providers name: _____

Date: _____

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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.

STATEMENT OF NONCONVICTION FOR TYPE B HOMES AND IN-HOME AIDES

This statement must be signed by every: certified type B home provider, emergency and substitute caregivers and all persons 18 years of age and older who reside in a type B home. This statement must be kept on file at the County Department of Job and Family Services (CDJFS).

Name (please print or type)

I hereby attest that I have never been convicted of or pleaded guilty to crimes set forth in divisions (A)(8) or (A)(9) of section 109.572 or division (A)(1) of 5104.09 of the Revised Code and that no child has been removed from my home as described in section 2151.353 of the Revised Code.

I am unable to sign the statement above because I have had a child removed from my home as described in section 2151.353 of the Revised Code.

I am unable to sign the statement above because I have been convicted of a crime included in divisions (A)(8) or (A)(9) of section 109.572 or division (A)(1) of 5104.09 of the Revised Code.

Signature of Person Completing Form

Date

Street Address

City

State

Zip Code

Telephone Number

The certified provider of a type B home must sign the following statement: I hereby attest that no one who resides in my home and who is under eighteen years of age has been adjudicated a delinquent child for committing a violation of any offense listed in divisions (A)(8) or (A)(9) of section 109.572 or division (A)(1) of 5104.09 of the Revised Code.

Signature

Date

Note: Anyone who withholds information from, or falsifies information on this statement is guilty of falsification, a misdemeanor of the first degree. If the offender is an a type B home provider or an in home aide the conviction constitutes grounds for denial, revocation, or refusal to renew a child care license application or child care certification. If the offender is an employee of a center or type A home, or is a person eighteen years of age or older who resides in a type A or type B home or is an emergency or substitute caregiver, and if the owner or licensee had knowledge of, and acquiesced in the commission of the offense, the conviction constitutes grounds for denial, revocation, or refusal to renew a child care license application or child care certification.

Note: effective June 1, 2008 all civilian background checks must be submitted electronically through use of WebCheck or other approved methods. More information can be found at: www.webcheck.ag.state.oh.us.

▼ TO BE SIGNED BY THE COUNTY CHILD CARE WORKER

I have reviewed the rehabilitation requirements of rule 5101:2-14-11 of the Administrative Code, and have determined that person named above meets the rehabilitation requirements. The attached documents verify that the requirements for rehabilitation have been met.

CDJFS Worker Signature

Date

The county child care worker for the type B home or in-home aide is required to sign and date below verifying that fingerprints have been electronically submitted to the Ohio Bureau of Criminal Identification and Investigation (BCII), or mailed if electronic processing exemption criteria are met.

A criminal records check for the above named individual was requested on (date) _____

Ohio BCII records check Federal Bureau of Investigation (FBI) records check (please check)

Signature of CDJFS worker

Date

I have reviewed the results of this person's criminal records check on the following dates: _____ Ohio BCII records check, _____ FBI records check. Section 109.572 (A) of the Revised Code requires the results of these records checks to be reviewed and approved by the CDJFS worker prior to certification of the type B home or in-home aide.

Signature of CDJFS worker

Date

This is a prescribed form which must be used to meet the requirements of rule 5101:2-14-11 of the Administrative Code.

STATEMENT OF NONCONVICTION FOR TYPE B HOMES AND IN-HOME AIDES

This statement must be signed by every: certified type B home provider, emergency and substitute caregivers and all persons 18 years of age and older who reside in a type B home. This statement must be kept on file at the County Department of Job and Family Services (CDJFS).

Name (please print or type)			
<input type="checkbox"/>	I hereby attest that I have never been convicted of or pleaded guilty to crimes set forth in divisions (A)(8) or (A)(9) of section 109.572 or division (A)(1) of 5104.09 of the Revised Code and that no child has been removed from my home as described in section 2151.353 of the Revised Code.		
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Signature of Person Completing Form			Date
Street Address			
City	State	Zip Code	Telephone Number
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Signature			Date

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Ohio BCII records check Federal Bureau of Investigation (FBI) records check (please check)

Signature of CDJFS worker			Date
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Signature of CDJFS worker			Date
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