ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

☐ Family Child Care Provider
☐ In-Home Provider

CERTIFIED FAMILY CHILD CARE PROVIDER APPLICATION

APPLICANT'S FULL LEGAL NAME *(Last, First, Middle)*	DATE RECEIVED BY DEPARTMENT

AREA CODE AND PHONE NO.	SOC. SEC. NO.	APPLICANT'S BIRTHDATE
( )		

APPLICANT'S RESIDENTIAL ADDRESS *(No., Street, City, State, ZIP)*

APPLICANT'S MAILING ADDRESS *(If different from residential)*	EMAIL ADDRESS
DIRECTIONS TO HOME	PREFERRED LANGUAGE ☐ English ☐ Spanish

APPLICANT'S RACE *(You may voluntarily indicate your race and ethnic background)*
☐ AI (American Indian or Alaskan Native) ☐ AS (Asian) ☐ BL (Black or African-American)
☐ NH (Native Hawaiian or other Pacific Islander) ☐ WH (White)

APPLICANT'S ETHNICITY
Hispanic ☐ Yes ☐ No

Are you a U.S. citizen? ☐ Yes ☐ No
If No, are you legally eligible to work in the U.S.? ☐ Yes ☐ No You will be required to provide documentation.
Are you an enrolled member of an American Indian tribe? ☐ Yes ☐ No If yes, which tribe? _____

APPLICANT
ALL OTHER NAMES USED *(List complete names, maiden name, nicknames, aliases, other spellings, other married names)*

PREVIOUS MARRIAGES ☐ **Yes** ☐ **No** **If Yes, list all previous spouses' names below.**	**PREVIOUS MARRIAGES** ☐ **Yes** ☐ **No** **If Yes, list all previous spouses' names below.**
Applicant:	Spouse:

HOUSEHOLD MEMBERS

(Include your spouse. Use complete names, maiden names, nicknames, other married names, etc.)

Name *(Last, First, Middle)*	Birthdate	Soc. Sec. No.	Relationship to Applicant	18 Years or Older
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Use the CC-200-A to list additional household members and Adult and Minor Children Out-of-Home.
I understand that any person who is present in my home for 21 days or more will be considered to be a household member.
I also understand that the above shall not be the sole consideration of who is a household member.

ADULT AND MINOR CHILDREN OUT-OF-HOME

(Include spouse's children and stepchildren. Use complete names, maiden names, nicknames, other married names, etc.)

Name *(Last, First, Middle)*	Birthdate	Soc. Sec. No.	Relationship to Applicant	18 Years or Older
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

APPLICANT'S COMPLETE NAME *(Last, First, Middle)*

REFERENCES

Please furnish the names of at least five adults, **not related to you**, who have known you for at least one year and can provide information regarding your abilities to **care for and nurture children**.

1. NAME *(Last, First, M.I.)*	AREA CODE AND PHONE NO. ( )
COMPLETE ADDRESS *(No., Street, City, State, ZIP)*	PREFERRED LANGUAGE ☐ English ☐ Spanish
2. NAME *(Last, First, M.I.)*	AREA CODE AND PHONE NO. ( )
COMPLETE ADDRESS *(No., Street, City, State, ZIP)*	PREFERRED LANGUAGE ☐ English ☐ Spanish
3. NAME *(Last, First, M.I.)*	AREA CODE AND PHONE NO. ( )
COMPLETE ADDRESS *(No., Street, City, State, ZIP)*	PREFERRED LANGUAGE ☐ English ☐ Spanish
4. NAME *(Last, First, M.I.)*	AREA CODE AND PHONE NO. ( )
COMPLETE ADDRESS *(No., Street, City, State, ZIP)*	PREFERRED LANGUAGE ☐ English ☐ Spanish
5. NAME *(Last, First, M.I.)*	AREA CODE AND PHONE NO. ( )
COMPLETE ADDRESS *(No., Street, City, State, ZIP)*	PREFERRED LANGUAGE ☐ English ☐ Spanish

HOUSING

☐ Own ☐ Rent ☐ House ☐ Apartment ☐ Mobile home ☐ Other *(Specify)* _____

If renting, an applicant must obtain written consent from the property owner.

BACK-UP CHILD CARE PROVIDER

The back-up provider must be at least 18 years of age and should be able to come to your home when necessary to provide care when you have to be out of the home for doctor's appointments, child care training, emergencies, etc. If you are using a child care center, DHS group home or DES-certified Family Child Care Provider as a backup, care can be provided at the backup's facility.

NAME OF BACK-UP PROVIDER *(Last, First, Middle)*	MAIDEN NAME, OTHER MARRIED NAMES, NICKNAMES, ETC.	AREA CODE AND PHONE NO. ( )
ADDRESS *(No., Street, City, State, ZIP)*	BIRTHDATE	SOC. SEC. NO.

REQUIREMENTS FOR PROVIDERS

Providers, their household members, and backup providers must be cleared through Child Protective Services Central Registry and CHILDS databases. The provider must supply proof of immunity from communicable diseases for which routine immunizations are readily and safely available *(applies to provider, backup provider and provider's children under 13 years of age)*. The provider, backup provider and all of the provider's household members must have a negative TB test annually. The provider must be interviewed and all adults must be fingerprinted. The provider and backup provider must be trained in infant/child CPR and first aid procedures within 60 days of completing certification. An applicant shall comply with all requirements of Article 52 and authorize the Department to obtain additional information as necessary to determine the applicant's ability to meet these requirements.

Providers are responsible for maintaining adequate child care liability insurance. Further, if the provider plans to transport children in care, the provider is responsible for maintaining at least minimum liability insurance on the car(s) used to transport children in care and have seat belts and child restraint seats as required by law.

COMPLIANCE WITH NON-DISCRIMINATION

Federal laws and regulations prohibit discrimination or the denial of benefits of or participation in Contract Services on the basis of race, color, national origin, religion, sex, age, handicap or political beliefs in programs receiving federal financial assistance. This Department has established a complaint procedure. If you feel you have been discriminated against because of your race, color, national origin, religion, sex, age, handicap or political beliefs, ask for a Hearing Request form (FA-503). Your worker will assist you in completing the form. Any intentional misrepresentation of facts on this application will result in denial of the application or revocation of the certificate or license.

SIGNATURE

APPLICANT'S SIGNATURE	DATE