

STATE OF MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Children's Licensing and Investigation Services

2 Anthony Avenue 11 State House Station Augusta, ME 04333-0011

Tel: (207) 287-5020 Fax: (207) 287-9304 Er

Fax: (207) 287-9304 Email: ocfschildrenslicensing.dhhs@maine.gov

Child Care Licensing Application

License #:				
SECTION 1: Program Information	n			
1. Program Name: (if you are a Family Child Care Provider and would like to use a "Business Name" enter it here)				
2. SSN/FEIN: (Required)				
3. Owner/Director Name (if Director is different enter name in # 4.):	Date of Birth:			
Former Names (i.e. maiden name, aliases):				
4. Director Name (Facility/Nursery School only):	Date of Birth:			
Former Names (i.e. maiden name, aliases):				
5. Physical Address of Child Care Program:				
Check only if one of the following applies:				
\square I am moving my existing location permanent \square I am moving my location temporarily not to \square	•			
Street Address:	Building Information:			
	Year the structure was built?			
City: State: Zip:	County:			
6. Mailing Address of Child Care Program:				
Street Address or Post Office Box:				
City: State: Zip:				
Program Phone No.: () - Fax No.: ()	-			
Email Address:				
SECTION 2: Program Type/Capacity/Age	Groups			
Maximum Capacity Requested:				
☐ <u>Family Child Care</u> : ☐ 3-6 ☐ 7-12				
What age ranges of children do you intend to serve?				
Check all that apply: ☐ 6 weeks – 2 years ☐ 2 – 5 years ☐ 5-12 years				
☐ Child Care Facility / Nursery School / Occasional Care Program:				
☐ 3–12 (Small Facility) ☐ 13-20 ☐ 21-49 ☐ 50 or more (indicate requested capacity):				
What age ranges of children do you intend to serve? Check all that apply:				
☐ 6 weeks – 12 months ☐ 13 – 36 months ☐ 3 - 5 years ☐ 5-12 years				

SECTION 3: Source of Water Supply				
☐ Municipal	☐ Well – Private Water Source	☐ Regulated by the Mai	ne Drinking	Water Program
A one-time first draw lead test is required.	A satisfactory water test for fluoride, uranium, arsenic, first draw lead sample, nitrates, and total coliform bacteria is required.	If you have 25 or more individ private water system, you mu Drinking Water Program. Plea contact the Maine CDC to beg	ist be regulated ise enter your	d by the Maine DWP ID Number or
	SECTION 4: Program	n Details		
Services: (If transporti	(Check all that agong please have the person(s) who will be train		the release fo	orm attached \
				☐ Head Start
Swimming Tr	ransportation Special Purpose (Sect	1011 28/CD3)	:22011 L	□ neau start
2. Attendance Options:				
☐ Full Day ☐ Partial	Day ☐ Drop in/Occasional ☐ Ever	ning 🗆 Weekend 🛭	☐ Summer	☐ Full week
☐ School Vacations	☐ School year ☐ Partial week	☐ Before School Care	☐ After :	School Care
	SECTION 5: Background	I Information		
 Are you now, or have you ever been, licensed, registered, or certified to provide services for children or adults? No If "yes", please indicate the type of care, approximate dates of service, and name(s) under which you are or were licensed, registered, or certified to provide services for children or adults: 				
 Have you had any prior license or certificate sanctions issued to you, such as a conditional license/certificate, license/certificate suspension, denial of an application for a license/certificate, fine, or revocation regarding a child or adult care license, certificate, or approval issued to you? No Yes, please explain: 				
3. Have you, or has anyone employed by you, (or, for family child care providers has anyone living in or frequenting your home) been:				
a. Convicted of a cr	ime, including OUI and/or vehicle offens	es?	□ No	☐ Yes
b. Investigated by Child Protective Services or the Out of Home Investigation Team?		□ No	☐ Yes	
c. Named as a defendant in a Protection from Abuse Order?		□ No	☐ Yes	
d. Named in a cour	t order resulting in removal of children fr	rom care or custody?	□ No	☐ Yes
If you checked yes to any of the above, please explain: Failure to provide accurate and/or complete information may be grounds for denial and/or constitute a Class D crime.				
4. Have you ever receiv ☐ No ☐ Yes, please explai	ed treatment for drug and/or alcohol us	e?		
5. Is there any other inf No Yes, please explai	formation that would be useful in assessin:	ng your ability to provide	care for chil	dren?

SECTION 6: Declaration					
I/We have received, read and understand the Rules governing the type of child care program for which I am/we are applying (select one):					
 State of Maine Child Care Facility Licensing Rule, Child Care Programs (effective 9/27/21) 	Centers, Nu	ırsery School	s, Small Child	Care Facilition	es, Other
$\ \square$ State of Maine Family Child Care Provider Licensing Rule (ef	fective 5/27	7/21)			
I/We understand that this application authorizes representatives of Fire Marshal's Office to make such visits and inspections as may be relaws and rules pertaining to the operation of child care programs.	-				
I/We also understand that the signing of this application effectively sometiment of Health and Human Services to obtain any criminal, characteristics for owner/operator/director which may be on file in any Countries of the services of the	nild protecti	ve, Out of Ho	me Investigat		
I/We understand that failure to disclose any criminal convictions, inc denial of this application.	cluding oper	ating under t	he influence	(OUI), may r	esult in
I/We certify that all information contained in this application is com statement may be grounds for denial and may be Unsworn Falsificat	-			=	on of
Print name of Program Owner Signature of Program Owner			Date		
Print name of Director/Co-Applicant Signa	ture of Dire	ctor/Co-App	 licant		Date
SECTION 7: Fees (NO FEE R	EQUIRED	at this time	e)		
Program Type: Family Child Care Child Care Facility Nursery School					
Fee Calculation		Family	Child Care	Nurson	Total
Application Type:	Program Type:	Child Care	Facility	Nursery School	
☐ New application (May take 3 or more months)		\$80	\$120	\$10	\$
☐ Renewal (Due 60 days prior to expiration)			\$240	\$10	\$
☐ Relocation of my currently licensed program			\$120	\$10	\$
☐ Change in Capacity		\$10			\$
☐ Change in Ages Served		\$10			
☐ Change in Director (Facility/Nursery Only) \$10				\$	
Total check/money order enclosed:				\$	
SECTION 8: Submission Attachments					
Please submit the following documents with your completed application to: Children's Licensing and Investigation Services, 2 Anthony Avenue, 11 State House Station, Augusta, ME 04333-0011.					
NOTE: NO FEE REQUIRED at this time ☐ A non-refundable check or money order made payable to "Treasurer, State of Maine" ☐ Authorization for Release of Information (if applicable) Note: Required for all adult household members and/or all individuals who will be transporting children					
Applications for <u>increase in capacity</u> must also include: Documentation of zoning/code approval from the municipality where the program is physically located.					
INCOMPLETE APPLICATIONS WILL BE RETURNED.					

Authorization for the Release of	Personal History Information
Program Name:	Program Number:
By signing below, I authorize the release of confidential records or in Out of Home Investigation record, and/or motor vehicle record to the Licensing and Investigation Services. I understand that any informatic confidential, as required by law, and will be used solely for the purposhould be granted or renewed. This consent may be revoked by me, been obtained.	the Department of Health and Human Services, Children's on obtained as a result of this release of information will remain use of determining whether a license to operate a child care
I understand that each adult member (18 years and older) of my hou Member(s), must complete the lower portion of this form upon requ licensing rules and may result in licensing action.	• • • • • • • • • • • • • • • • • • • •
Prior to transporting children, a Bureau of Motor Vehicle check, mufor any individual(s) who will be transporting.	ist be completed, submitted and approved by the Department
Program Owner Name: Street Address: City, State & Zip: Telephone #: Date of Birth: Former/Maiden Name(s): Driver's License #: Will be transporting shildren: \(\Pi \) No. \(\Pi \) Yes	Program Director Name: Street Address: City, State & Zip: Telephone #: Date of Birth: Former/Maiden Name(s): Driver's License #: Will be transporting children:
Will be transporting children: ☐ No ☐ Yes	Will be transporting children: ☐ No ☐ Yes
Signature:	Signature:
Adult Household Member By signing below, Adult Household Members, Staff and Volunteers a Children's Licensing and Investigation Services to obtain and disclose criminal record, substantiated Child Protection Services record, substantiated or motor vehicle record to the program owner named above.	uthorize the Department of Health and Human Services, confidential records or information regarding that person's
Full Name:	Full Name:
Street Address:	Street Address:
City, State & Zip:	City, State & Zip:
Telephone #:	Telephone #:
Date of Birth:	Date of Birth:
Former/Maiden Name(s):	Former/Maiden Name(s):
Driver's License #:	Driver's License #:
Will be transporting children: \square No \square Yes	Will be transporting children: \square No \square Yes
Signature:	Signature:
Full Name:	Full Name:
Street Address:	Street Address:
City, State & Zip:	City, State & Zip:
Telephone #:	Telephone #:
Date of Birth:	Date of Birth:
Former/Maiden Name(s):	Former/Maiden Name(s):
Driver's License #:	Driver's License #:
Will be transporting children: ☐ No ☐ Yes	Will be transporting children: \square No \square Yes
Signature:	Signature: