

OFFICE OF INSPECTOR GENERAL - LICENSING DIVISION

Family Child Care License Application

This application is intended for both Family Child Care (FCC) and Special Family Child Care (SFCC) programs referenced in MN Statutes Chapter 245A. A SFCC program is defined as a nonresidential child care program serving 14 or fewer children that is conducted at a location other than the license holder's own residence. A program located in the license holder's primary residence shall be licensed as a FCC. Complete the application below and submit to your county licensing agency along with all required documentation as indicated by your county agency. Your county agency will contact you to discuss next steps.

An applicant is legally responsible for the operation of the program when licensed and can be an individual(s) or an organization. Check the applicable type and provide information on all entities that will hold the license.

WHAT ARE YOU APPLYING FOR?

New license License renewal License update

IF APPLYING FOR A LICENSE UPDATE, WHAT DO YOU NEED TO UPDATE?

Program address License class Other

IF OTHER, PLEASE SPECIFY:

Applicant

TYPE OF APPLICANT: individual(s) organization

IF ORGANIZATION, WHAT TYPE? employer church/religious community collaborative not-for-profit

Required documentation for an **employer program** includes a program plan and a letter from the employer acknowledging their responsibility as the license holder for maintaining the program's compliance with licensing requirements.

Required documentation for a **church/religious program** includes a program plan and a letter from the church or religious organization acknowledging their responsibility as the license holder for maintaining the program's compliance with licensing requirements.

Required documentation for **community collaborative programs** includes a program plan and a copy of the cooperative agreement the community collaborative child care provider has with the community action agency.

Required documentation for **not-for-profit programs** includes a program plan and copies of the contracts that the not-for-profit agency maintains with community employers or organizations to provide child care services.

APPLICANT NAME

STREET ADDRESS (INCLUDE P.O. BOX IF NEEDED FOR MAIL DELIVERY)		CITY	STATE	ZIP CODE
PHONE NUMBER	ALTERNATE PHONE NUMBER		EMAIL	

For individual applicants only: If a second individual is applying, include their information here:

APPLICANT NAME

STREET ADDRESS (INCLUDE P.O. BOX IF NEEDED FOR MAIL DELIVERY)		CITY	STATE	ZIP CODE
PHONE NUMBER	ALTERNATE PHONE NUMBER		EMAIL	

For individual applicants only: If a third individual is applying, include their information here:

APPLICANT NAME				
STREET ADDRESS (INCLUDE P.O. BOX IF NEEDED FOR MAIL DELIVERY)		CITY	STATE	ZIP CODE
PHONE NUMBER	ALTERNATE PHONE NUMBER		EMAIL	

Information about the program

Information about the program is the same as the applicant information

PROGRAM NAME/DOING BUSINESS AS				
STREET ADDRESS (INCLUDE P.O. BOX IF NEEDED FOR MAIL DELIVERY)		CITY	STATE	ZIP CODE
COUNTY	PHONE NUMBER	IS THIS PROGRAM REGISTERED WITH THE MN SECRETARY OF STATE? <input type="radio"/> Yes <input type="radio"/> No		
IF YES, PLEASE ENTER THE FILING NUMBER:				

Additional controlling individual(s)

FULL NAME		TITLE		
STREET ADDRESS (INCLUDE P.O. BOX IF NEEDED FOR MAIL DELIVERY)		CITY	STATE	ZIP CODE
PHONE NUMBER	TYPE OF CONTROLLING INDIVIDUAL (CHECK ALL THAT APPLY) <input type="checkbox"/> Owner <input type="checkbox"/> Managerial official <input type="checkbox"/> Primary provider of care <input type="checkbox"/> CEO <input type="checkbox"/> CFO <input type="checkbox"/> President <input type="checkbox"/> Treasurer <input type="checkbox"/> Other officer			
IF OWNER, WHAT PERCENTAGE		IF OTHER OFFICER, WHAT TITLE		

FULL NAME		TITLE		
STREET ADDRESS (INCLUDE P.O. BOX IF NEEDED FOR MAIL DELIVERY)		CITY	STATE	ZIP CODE
PHONE NUMBER	TYPE OF CONTROLLING INDIVIDUAL (CHECK ALL THAT APPLY) <input type="checkbox"/> Owner <input type="checkbox"/> Managerial official <input type="checkbox"/> Primary provider of care <input type="checkbox"/> CEO <input type="checkbox"/> CFO <input type="checkbox"/> President <input type="checkbox"/> Treasurer <input type="checkbox"/> Other officer			
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IF OWNER, WHAT PERCENTAGE		IF OTHER OFFICER, WHAT TITLE		

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IF OWNER, WHAT PERCENTAGE		IF OTHER OFFICER, WHAT TITLE		

Tax identification information

You must provide your Minnesota Tax ID Number if you have one. The Minnesota Department of Revenue requires a business to have a Minnesota Tax ID if it collects sales tax on retail sales in Minnesota; has employees and collects withholding taxes; or is a corporation doing business in Minnesota and files a tax return with the Department of Revenue. For more information, visit the [Minnesota Department of Revenue](#) website. You are required to provide your Federal Employer ID Number (FEIN) if you have one. This is a nine-digit number from the Internal Revenue Service (IRS) because you have employees or operate your business as a corporation or partnership.

Individual applicants and license holders must also provide their Social Security Number (SSN). If the FEIN and the SSN are both entered, the FEIN will be used for tax purposes and the SSN will be used for identification purposes only. Tax information is not public, except that under section 270C.72, DHS is required to provide the Minnesota Department of Revenue the tax ID number and the SSN of each license applicant.

Under the Minnesota Government Data Practices Act, we must advise you that:

- i. This information may be used to deny the issuance of a license, or to revoke a license if you owe the Minnesota Department of Revenue delinquent taxes, penalties, or interest.
- ii. DHS will only provide the tax ID information to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Act, the Department of Revenue is allowed to supply this information to the IRS.

MINNESOTA TAX ID NUMBER (IF APPLICABLE)	FEDERAL EMPLOYER ID - FEIN (IF APPLICABLE)	SOCIAL SECURITY NUMBER
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Current and past licenses

HAVE YOU EVER HAD A LICENSE DENIED BY DHS? <input type="radio"/> Yes <input checked="" type="radio"/> No		
DO YOU HOLD OR HAVE YOU EVER HELD A LICENSE ISSUED BY DHS? <input type="radio"/> Yes <input checked="" type="radio"/> No		
IF YES AND YOU KNOW THE LICENSE NUMBER, ENTER IT HERE:	COUNTY OR AGENCY THAT ISSUED THE LICENSE	STATE
LICENSE TYPE <input type="radio"/> FCC <input type="radio"/> CFC <input type="radio"/> AFC <input type="radio"/> FADS <input type="radio"/> Other	WAS THIS LICENSE EVER REVOKED? <input type="radio"/> Yes <input type="radio"/> No	

IF YES AND YOU HAVE A SECOND LICENSE NUMBER, ENTER IT HERE:		
COUNTY OR AGENCY THAT ISSUED THE LICENSE		
STATE		
LICENSE TYPE <input type="radio"/> FCC <input type="radio"/> CFC <input type="radio"/> AFC <input type="radio"/> FADS <input type="radio"/> Other	WAS THIS LICENSE EVER REVOKED? <input type="radio"/> Yes <input type="radio"/> No	

IF YES AND YOU HAVE A THIRD LICENSE NUMBER, ENTER IT HERE:	COUNTY OR AGENCY THAT ISSUED THE LICENSE	STATE
LICENSE TYPE <input type="radio"/> FCC <input type="radio"/> CFC <input type="radio"/> AFC <input type="radio"/> FADS <input type="radio"/> Other	WAS THIS LICENSE EVER REVOKED? <input type="radio"/> Yes <input type="radio"/> No	

Program location/dwelling information

BUILDING TYPE (SELECT ONE) <input type="radio"/> Single family home <input type="radio"/> Duplex/Twin home <input type="radio"/> Apartment/Condo <input type="radio"/> Townhouse <input type="radio"/> Mobile home <input type="radio"/> Commercial space <input type="radio"/> Religious (church, synagogue, mosque, temple, etc.) <input type="radio"/> Other	BUILDING AMENITIES (CHECK ALL THAT APPLY) <input type="checkbox"/> Basement <input type="checkbox"/> Second Floor <input type="checkbox"/> Above second floor <input type="checkbox"/> Attached garage <input type="checkbox"/> Wood burning stove/fireplace
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BUILDING OWNERSHIP Owned Rented

DO YOU LIVE AT THIS LOCATION? Yes No

ARE OTHER INDIVIDUALS BESIDES YOU LIVING AT THIS LOCATION OR WORKING IN THE PROGRAM? IF YES, PLEASE LIST. Yes No

FULL NAME (LAST, FIRST, MI)	JOB TITLE OR RELATIONSHIP	DATE OF BIRTH
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STATUS
 Works in the program ONLY Lives at the program location ONLY Both lives AND works in the program

FULL NAME (LAST, FIRST, MI)	JOB TITLE OR RELATIONSHIP	DATE OF BIRTH
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STATUS
 Works in the program ONLY Lives at the program location ONLY Both lives AND works in the program

FULL NAME (LAST, FIRST, MI)	JOB TITLE OR RELATIONSHIP	DATE OF BIRTH
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STATUS
 Works in the program ONLY Lives at the program location ONLY Both lives AND works in the program

FULL NAME (LAST, FIRST, MI)	JOB TITLE OR RELATIONSHIP	DATE OF BIRTH
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STATUS
 Works in the program ONLY Lives at the program location ONLY Both lives AND works in the program

References (required for initial application only)

FIRST NAME	MI	LAST NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

FIRST NAME	MI	LAST NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

FIRST NAME	MI	LAST NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

References for co-applicant (if any - required for initial application only)

FIRST NAME	MI	LAST NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

FIRST NAME	MI	LAST NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

FIRST NAME	MI	LAST NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

License class

SELECT ONE:

	Adult	Total capacity	Total under school age	Total infants and toddlers	Maximum infants
<input type="radio"/> A-Family	1	10	6	3	2
<input type="radio"/> B1-Family (specialized infant/toddler)	1	5	3	3	3
<input type="radio"/> B2-Family (specialized infant/toddler)	1	6	4	4	2
<input type="radio"/> C1-Group Family	1	10	8	3	2
<input type="radio"/> C2-Group Family	1	12	10	2	1
<input type="radio"/> C3-Group Family	2	14	10	4	3
<input type="radio"/> D-Group (specialized infant/toddler)	2	9	7	7	4

Hours of operation

OPEN FROM THE MONTH OF:	THROUGH THE MONTH OF:
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Daily hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
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Workers' compensation insurance verification

You must submit the [Certificate of Compliance Minnesota Workers' Compensation Law Form](#) with your license application.

Applicant acknowledgment of public funding reimbursement

Under section 245A.04, subd. 1, DHS license holders who elect to receive any public funding reimbursement including Medical Assistance, Child Care Assistance Program (CCAP), and Federal Food Program Funds for the licensed services must acknowledge that they will comply with funding requirements, that compliance with those requirements may be monitored by DHS Licensing, and that they know the consequences for noncompliance with those requirements. As a DHS license applicant you must verify whether you intend to receive any public funding by checking the applicable box for item 1 or 2 below. If you check item 2, you are acknowledging the conditions stated in (a) to (c):

- 1. I **DO NOT** elect to receive any public funding reimbursement (including Medical Assistance, CCAP, and Federal Food Program Funds) for the licensed services.
- 2. I **DO** elect to receive public funding reimbursement for the licensed services and I acknowledge the following:
 - a.** I must comply with the provider enrollment agreement or registration requirements for receipt of public funding;
 - b.** My compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by DHS Licensing as part of a licensing investigation or licensing inspection; and
 - c.** That noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:
 - (1) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;
 - (2) nonpayment of claims submitted by the license holder for public program reimbursement;
 - (3) recovery of payments made for the service;
 - (4) disenrollment in the public payment program; or
 - (5) other administrative, civil, or criminal penalties as provided by law.

Applicant agreement, acknowledgment and verification

The **authorized agent** must review and approve the license application by signing below. For individual applicants, you are the authorized agent.

By signing below, the Authorized Agent agrees:

- The information provided on this application form is true, accurate and complete;
- If DHS grants a license, I agree the program will comply with the applicable licensing rules and statutes at all times;
- I understand DHS has the right to request any documentation required by Minnesota Rules or Laws and to inspect the facility/service at any time during the hours that services are provided;
- I understand that the documentation and inspection required by statutes and rules is necessary for DHS to determine whether I am complying with Minnesota Rules and Laws;
- I understand if I choose to receive public funding, I must comply with all applicable laws and rules, that compliance will be monitored by DHS, and that noncompliance may result in penalties;
- I understand DHS may fine, suspend, revoke or make conditional, or deny a license if an applicant or license holder fails to comply fully with the applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to DHS in connection with an application for a license or during an investigation.
- I am the Authorized Agent responsible for communicating with DHS throughout the application process, on all matters related to the applicable licensing rules and statutes and for accepting service of all notices and orders from DHS.

I declare under the penalty of perjury that everything I have stated in this document is true and correct.

SIGNATURE OF AUTHORIZED AGENT	DATE
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