Washington State Department of CHILDREN, YOUTH & FAMILIES

LICENSING DIVISION

Application for Child Care Agency License or Certification

1. TYPE OF APPLICATION
☐ First ☐ Renewal
☐ Certification
☐ Other

2. PROVIDER NUMBER

3. NAME OF FACILITY / AGENCY (OR PARENT ORGANIZATION, IF ANY)

4. ADDRESS OF FACILITY/AGENCY (OR PARENT ORGANIZATION, IF ANY) CITY STATE ZIP CODE

5. TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

6. NAME OF FACILITY/AGENCY BRANCH OR SUBDIVISION OF AGENCY, OR NAME BY WHICH AGENCY DOES BUSINESS (DBA)

7. ADDRESS OF FACILITY TO BE LICENSED IF DIFFERENT THAN ABOVE CITY STATE ZIP CODE

8. TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

9. MAILING ADDRESS IF DIFFERENT THAN ADDRESS ABOVE CITY STATE ZIP CODE

10. DIRECTIONS FOR REACHING FACILITY TO BE LICENSED

11. TYPE OF LICENSE REQUESTED
☐ Child placing agencies
☐ Crisis residential centers (Regular or Secure)
☐ Day treatment
☐ Emergency Respite Center
☐ Group care facility
☐ Group receiving facility
☐ Other (specify):
☐ Overnight youth shelter
☐ Staffed residential center
☐ Resource and assessment center

12. TYPE OF SERVICES PROVIDED (CHECK APPROPRIATE BOX(ES))
☐ Children with intellectual developmental disabilities
☐ Hope beds
☐ Other (specify):
☐ Medically fragile children
☐ Pregnant and parenting youth (maternity services)
☐ Responsible living skills program

13. HAVE YOU PREVIOUSLY BEEN LICENSED OR CERTIFIED?
☐ No ☐ Yes; If yes, indicate by what name and where:

14. FACILITY LOCATION (CHECK ONE)
☐ Incorporated city
☐ Unincorporated city

If you are aware of which local zoning, planning, or building code agency(ies) is responsible for the locality in which the facility will be located, please specify here

15. TYPE OF ORGANIZATION (CHECK APPROPRIATE BOX(ES)
☐ Individual
☐ Partnership or non-incorporated association
☐ Non-profit corporation
☐ Proprietary corporation
☐ For Profit corporation
☐ Governmental agency
☐ Indian tribe

16. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)

17. IS THE AGENCY LICENSED IN ANOTHER REGION?
☐ No ☐ Yes If yes, indicate location and type

18. DOES THE AGENCY PROVIDE SERVICES IN ANOTHER REGION?
☐ No ☐ Yes If yes, where

19. DOES THE AGENCY HAVE BRANCH OFFICES IN ANOTHER REGION?
☐ No ☐ Yes If yes, where

20. CLIENTELE PREFERRED	NUMBER	RANGE OF AGES PREFERRED
☐ Male ☐ Female ☐ Either Sex ☐ Expectant Mothers		TO ☐ No age preference

21. The Department of Children, Youth, and Families (DCYF) may not license, make referrals to, payments to, or include in its directories the names of agencies which discriminate in the provision of services because of race, creed, color, national origin, sex, or handicap, or which discriminates in employment practices because of race, creed, color, national origin, sex, handicap or age. I hereby agree not to engage in prohibited discriminatory practices.

I further certify that I have received, read, understand and agree to comply with the provisions of Chapter 74.15 of the Revised Code of Washington (RCW) (child care agency licensing statute), and with the provisions of WAC Chapter 388-145 or 388-147 of the Washington Administrative Code (WAC) (minimum licensing requirements) and WAC Chapter 388.06A Criminal History Background. I (we) also understand that corporal punishment of children in care is prohibited under the provisions of WAC 388-145 and agree to comply with this rule. I (we) hereby further certify that the above information and required attachments are true and complete to the best of my (our) knowledge and give permission for the DCYF to contact references and past employers, and to obtain personnel records from previous employers.

I (we) further understand that DCYF does a Washington State Patrol criminal history and background inquiry check and a check of FamLink files regarding any person(s) applying for a child care license and the person(s) employees, if any.

NOTE: WAC 110-145-1390 and 110-147-1410 of the Washington Administrative Code provides that a license shall be denied, suspended, revoked or not renewed for misrepresentation or material omissions on this application.

Signatures

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

22. Attach to this application any of the documents listed below which pertain to your agency. WAC or RCW references are indicated for easy referral to requirements. Please date all written information and forms. It is not necessary to submit these documents for a reapplication unless there have been changes in content.

a.	Articles of incorporation (if applicable)	RCW 74.15.070
b.	Documentation of compliance with local ordinance (building codes)	WAC 110-145-1355 WAC 110-147-1365
c.	List of staff	WAC 110-145-1325 WAC 110-147-1325
d.	Budget	WAC 110-145-1390 WAC 110-147-1410
e.	Discipline practices (Behavior Management Policy)	WAC 110-145-1815
f.	Personnel policies (for agencies employing 5 or more persons)	WAC 110-145-1335 and 1420(d) WAC 110-147-1520
g.	Forms used for client records and information	WAC 110-145-1520 and 1525 WAC 110-147-1525, 1530, 1655(6), 1720
h.	Transportation Insurance-Liability and Medical (include name of company and policy)	WAC 110-145-1755
i.	In-service training program (for group care facilities employing five (5) or more persons and all child placing agencies regardless of number employees this in-service training program must be in writing)	WAC 110-145-1495 WAC 110-147-1505
j.	Program description outlining the educational, recreational and therapeutic services (if any) to be provided to a child and the child's family. For residential services, include a schedule of typical daily activities for persons in care and a statement of religious practices if any.	WAC 110-145-1335 WAC 110-147-1335
k.	A floor plan of the facility drawn to scale (residential programs). A simple sketch is sufficient; blueprints are not required.	WAC 110-145-1670 WAC 110-145-1426
l.	Employment, education history, and resumes of persons charged with active agency management on forms prescribed by DCYF	WAC 110-145-1425 WAC 110-147-1445
m.	Completed forms for criminal history and child protective services checks for all persons who will have unmonitored access to children in care	WAC 110-145-1325 WAC 110-147-1325
n.	Water test report if water supply is from a private source (residential programs)	WAC 110-147-1585
o.	Written health plan	WAC 110-145-1635

Budget Guide		
	DATE FROM	DATE TO
23. Source of Funds for Current Fiscal year to Operate Agency:	ESTIMATED OR	ACTUAL
a. United Way		
b. Grants		
c. Contracts		
d. Other (specify):		
e. Other (specify):		
f. Other (specify):		
g. Other (specify):		
h. Other (specify):		
Totals	0	0
24. Expenses for Current Fiscal Year to Operate Agency:	ESTIMATED OR	ACTUAL
a. Rent or mortgage payments		
b. Utilities		
c. Wages or salaries and benefits		
d. Other professional fees		
e. Food		
f. Supplies (household)		
g. Supplies (program)		
h. Maintenance and repairs		
i. Equipment		
j. Insurance		
k. Taxes		
l. Vehicles and transportation		
m. General operations (telephone, postage, professional dues)		
n. Other (specify):		
o. Other (specify):		
p. Other (specify):		
q. Other (specify):		
r. Other (specify):		

25. Agency Management

A. Executive Director / CEO (Attach Resume)

NAME	TITLE	BIRTH DATE	DATE EMPLOYED	MONTHLY SALARY	HOURS PER WEEK

EXPERIENCE FOR THIS POSITION		EDUCATION		
YEARS	TYPE	HIGHEST GRADE ACHIEVED HIGH SCHOOL/COLLEGE	DEGREE	AREA OF SPECIALIZATION

REFERENCES

NAME	ADDRESS	TELEPHONE NUMBER

B. Director (Attach Resume)

NAME	TITLE	BIRTH DATE	DATE EMPLOYED	MONTHLY SALARY	HOURS PER WEEK

EXPERIENCE FOR THIS POSITION		EDUCATION		
YEARS	TYPE	HIGHEST GRADE ACHIEVED HIGH SCHOOL/COLLEGE	DEGREE	AREA OF SPECIALIZATION

REFERENCES

NAME	ADDRESS	TELEPHONE NUMBER

C. Program Supervisor (Attach Resume)

NAME	TITLE	BIRTH DATE	DATE EMPLOYED	MONTHLY SALARY	HOURS PER WEEK

EXPERIENCE FOR THIS POSITION		EDUCATION		
YEARS	TYPE	HIGHEST GRADE ACHIEVED HIGH SCHOOL/COLLEGE	DEGREE	AREA OF SPECIALIZATION

REFERENCES (ONLY IF PROGRAM SUPERVISOR IS DIFFERENT FROM DIRECTOR)

NAME	ADDRESS	TELEPHONE NUMBER

26. Staffing										
POSITION TITLE	EMPLOYEE'S NAME	BIRTH DATE	EXPERIENCE FOR THIS POSITION		EDUCATION			DATE EMPLOYED	MONTHLY SALARY	HOURS PER WEEK
			YEARS	TYPE	HIGHEST GRADE ACHIEVED HIGH SCHOOL/COLLEGE	DEGREE	AREA OF SPECIALIZATION			

Instructions

This is an application for the following classes of facilities:

a. Child placing agencies
b. Crisis residential centers (Regular or Secure)
c. Day treatment
d. Emergency Respite Center
e. Group care facility
f. Group receiving center
g. Overnight youth shelter
h. Resource and assessment center
i. Staffed residential center

Mail application to the Department of Children, Youth, and Families (DCYF), Licensing Division (LD) Regional Licensing.

1. Type of Application: Enter "X" in the appropriate box, i.e., indicate whether this is applicant's first license application in this state or whether this is a current license renewal application (licensees should request license renewal 3 months prior to the expiration of a current license).
2. Provider Number: If this is a new license, this is not applicable. During the licensing process, every provider is issued a provider number.

3 and 4. If an applicant facility / agency is not a branch or subdivision of another agency, enter the name of the applying agency as it appears in its articles of incorporation or the incorporated name of any applicant.

5. Telephone and Fax number including area code and e-mail address.

6 and 7. If an applicant is a branch or subdivision of any agency, enter its name and/or the name, or names, by which the applicant agency does business, or is commonly known, or has recently been known. This should be the address at which the agency being licensed does business.

8. Telephone and Fax number including area code and e-mail address.
9. If a post office box is used, or if mail for branches is received at the parent organization, make notation here.
10. Give directions from the nearest major thoroughfare.
11. Type of license requested: Enter "X" in the appropriate box(es).
12. Type of services the agency or facility will provide: Enter "X" in the appropriate box(es)
13. Self-explanatory.
14. DCYF policy requires local zoning, planning, and building code agencies be informed of the receipt of an application to establish group care facilities, day treatment programs, maternity homes, and crisis residential centers. DCYF will use information in this section for this purpose. Do not complete this section on an application for relicensing. (Compliance with local ordinances remains the responsibility of the applicant/licensee, who should contact appropriate local authorities.)
15. Check appropriate box.
16. Provide the Federal Employer Identification Number (FEIN) for payment purposes.

17, 18, and 19. Self-explanatory.

20. Clientele Preferred: place an "X" in the appropriate box indicating the sex of the person(s) applicant prefers to care for. Under "number," enter the maximum number the applicant desires to care for in the space provided. Indicate the range of ages of person for whom the applicant would like to care, or place an "X" in the box labeled "no age preference." This includes licensing for any category of care for children.
21. The chairman of the board signs the application if the agency is board sponsored; otherwise, by the agency owner.
22. Attachments: in addition to explanatory statements, if any items in numbers 14, 15, or 16 were checked "Yes," DCYF requires you submit the documents listed in number 19 as required for the different particular class of license requested before an application can be considered complete. With an application for license renewal, it is not necessary to resubmit these documents unless there has been a significant change making the documents originally submitted inaccurate or obsolete.

23 and 24. Sufficient information should be provided so that consideration of the estimated income and expenditures may be used to determine if the agency has the financial ability to comply with the minimum requirements.

25. Note the name(s) of the person(s) charged with active management. References should be obtained for each of the applicants. List names, addresses, and telephone numbers of three persons who know applicant well and who can testify to the applicant's character and ability to provide care to other persons. Do not list more than one relative. DCYF may make additional inquiries, as it deems necessary.
26. Staff: complete all columns for each employee. Make this a complete staff list (add additional pages as necessary). Include part-time case workers supplied by a parent agency (or other agency) when such workers also have duties and caseloads not related specifically to the facility. List positions you contemplate filling for the number of children served, even though staff have not been hired.