children's council SAN FRANCISCO
because child care matters

Child Care Resource & Referral Provider Application

Thank you for your interest in being listed in our Referral Database. Please complete this application so that we can provide detailed and accurate information about your child care program. Please return the completed application and **a copy of your child care license** to our Resource & Referral Department at 445 Church Street, San Francisco CA 94114.

PROVIDER INFORMATION **Date:** _____

Provider Name (as it appears on license): _____

Alternate Name (If different from license): _____

Contact (Centers: Director Name): _____ Facility Phone: _____

Corporate/Main Phone: _____ Fax: _____ Email: _____

Facility Address: _____ Website: _____

Mailing Address (Centers only): _____

Check all that apply: ☐ School Age Option ☐ Toddler Option

LICENSES – FAMILY CHILD CARES ONLY

Age Group	Capacity	License Number	Desired Capacity	Subsidized Slots	Child Ages From:		To:		Vacancies
					___ Yr.	___ Mo.	___ Yr.	___ Mo.	
Family Child Care (FCC)									

What is the adult-to-child ratio in your facility: Number of adults: _____ Number of children: _____

LOCATION

Cross Street: _____ Area/Neighborhood: _____

Transportation (Check all that apply): ☐ Bus ☐ Provider Drives ☐ Provider Walks

Bus Routes: _____ Schools near you (if you offer after school programs): _____

SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:

☐ 24 Hours ☐ Flexible ☐ Non-Traditional Hours

Daily Schedule (Check ALL that apply):

☐ Full Time ☐ Part Time ☐ Before School ☐ After School ☐ Drop In ☐ Days ☐ Evenings
☐ Overnight ☐ Rotate/Variable

Yearly Schedule (Check ALL that apply): ☐ School Year ☐ Summer ☐ Full Year ☐ Other

RATES

Age Group	Monthly		Weekly		Daily		Hourly	
	Full Time	**Part Time**	**Full Time**	**Part Time**	**Full Time**	**Part Time**	**Full Time**	**Part Time**
Infant (0-2 yrs)								
Preschool (2-5 yrs)								
School Age (6+ yrs)								

REGISTRATION FEE (SELECT ONE)

☐ None ☐ Once: Amount_____ ☐ Annually: Amount $_____

QUALIFICATIONS

Your native language:_____ Accreditations:_____

Other language Spoken:_____

Brief description of any experience working with children with special needs:_____

_____

_____

Education or training to work with children with special needs (check all that apply):

☐ Behavioral/Emotional/Psychological
☐ Child Protective Services
☐ Communication/Language
☐ Developmental Disability
☐ Developmental Delays
☐ Exceptional Needs
☐ Infant
☐ Other: _____

☐ Limited English
☐ Physical Disability
☐ Special Equipment/ Dietary Needs
☐ Severely Handicapped
☐ Special Health/ Medical Needs
☐ Visual/Hearing
☐ Learning Disability

Training (check all types of training you have completed and date completed):

☐ AA (Associate of Arts)	Date Completed: _____	Units:_____
☐ BA (Bachelor of Arts)	Date Completed: _____	Units:_____
☐ CCIP (Child Care Initiative Project)	Date Completed: _____	Units:_____
☐ ECE (Early Childcare Education)	Date Completed: _____	Units:_____
☐ Workshop: _____	Date Completed: _____	Hours:_____
☐ Other: _____	Date Completed: _____	Units/Hours: _____

Your Program Details

Programs: ☐ Academic ☐ Co-Op ☐ Developmental ☐ Community-based ☐ Play-based
☐ Special Needs ☐ Sick Care ☐ Montessori ☐ Reggio Emilia ☐ Waldorf
☐ Religion, please specify religion _____
☐ Language immersion, please specify language _____
☐ Other _____

Food Program: ☐ Yes, Sponsor: _____ ☐ No

Subsidies: ☐ PFA ☐ CDE-State Preschool ☐ CDE-Other (Not state Pres.) ☐ Head Start
☐ Sibling Discount ☐ Scholarship ☐ Family & Children Services (FCS) ☐ City Money
☐ Vendor Vouchers (Children's Council Vouchers) ☐ Access ☐ Other:_____

Do you provide care for mildly ill children? ☐ Yes ☐ No

Do you provide care for non-potty trained children? ☐ Yes ☐ No

Do you provide Foster Care? ☐ Yes ☐ No

Additional Information:

☐ Apartment
☐ House
☐ Diapers
☐ Formula
☐ Pets
☐ Pool/Spa On site
☐ Wheelchair Accessible

Meals Served:

Provider	**or**	Parent
☐	Breakfast	☐
☐	AM Snack	☐
☐	Lunch	☐
☐	PM Snack	☐
☐	Dinner	☐
☐	Late Snack	☐

Provider Statement to Potential Families: Please write a brief description/advertisement of your facility. This text will print on referrals sent to callers seeking child care.

_____

_____

_____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY
NoHo ID: _____
CCR&R Staff: _____
Date: _____