

# Minnesota Department of Human Services Notice of Privacy Practices

(Effective Date: August 2011)

**This notice tells how medical and other private information about you may be used and disclosed and how you can get this information. Please review it carefully.**

## Why do we ask for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services and decide if you can pay for some services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your family need protective services
- To collect money from the state or federal government for help we give you.

## Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you medical assistance, some kinds of financial help, or child support enforcement services (42 CFR 435.910 [2006]; Minn. Stat. 256D.03, subd.3(h); Minn. Stat.256L.04, subd. 1a; 45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]). We also need your SSN to verify identity and prevent duplication of state and federal benefits. Additionally, your SSN is used to conduct computer data matches with collaborative, nonprofit and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the SSN:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a U.S. citizen and are applying for Emergency Medical Assistance only
- If you are from another country, in the U.S. on a temporary basis and do not have permission from the

U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently

- If you are living in the U.S. without the knowledge or approval of the USCIS.

## Do you have to answer the questions we ask?

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

## With whom may we share information?

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

We may disclose your health information to a record locator service. This can help health care providers find health plans and other health care providers that have health information about you. The health care provider can then get that information to help make better decisions about your treatment. If you prefer not to be included in the record locator service, you may "opt out" by contacting the Community Health Information Collaborative (CHIC) service desk at (877) 411-CHIC (toll free), 218-625-5515 (voice), 218-625-5518 (fax).

### **What are your rights regarding the information we have about you?**

- You and people you have given permission to may see and copy medical or other private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations with whom we have shared your information. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

### **What are our responsibilities?**

- We must protect the privacy of your medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at:

[http://edocs.dhs.state.mn.us/lfsrver/  
Public/DHS-3979-ENG](http://edocs.dhs.state.mn.us/lfsrver/Public/DHS-3979-ENG)

### **What privacy rights do children have?**

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

### **What if you believe your privacy rights have been violated?**

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either to the county agency, the organization or to the federal civil rights office at:

U.S. Department of Health and Human Services  
Office for Civil Rights, Region V  
233 N. Michigan Avenue, Suite 240  
Chicago, IL 60601  
(312) 886-2359 (Voice) or  
toll free (800) 368-1019 or (866) 282-0659  
(312) 353-5693 (TTY)  
(312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

Minnesota Department of Human Services  
Attn: Privacy Official  
PO Box 64998  
St. Paul, MN 55164-0998

**CHISAGO COUNTY HUMAN SERVICES**

**Statement of Account**

**FOR YOUR PROTECTION: Secure your check with the "Statement of Account" by enclosing them both in the envelope provided; staple this envelope to any document you are returning to our agency for the purpose of family child care relicensing.**

**Check payable to:** *Chisago County Human Services*

**Agency mailing address:** 6133 402nd Street  
North Branch, MN 55056-6097

**Applicant:**

\_\_\_\_\_  
Name License Type: Family Child Care  
\_\_\_\_\_  
Address Amount Paid: \_\_\_\_\_  
\_\_\_\_\_  
City, State Zip Check No.: \_\_\_\_\_

**Family Child Care Relicensing fees:**

Background Studies.....\$100.00 \_\_\_\_\_  
Licensing Fee (2 years).....\$100.00 \_\_\_\_\_

*(Please send top portion with payment)*

*(Please retain bottom portion with your child care records)*

**Family Child Care Relicensing fees:**

Background studies.....\$100.00  
Licensing fee (2 years).....\$100.00

Total Amount Due.....**\$200.00**

**Applicant:**

\_\_\_\_\_  
Name License Type: Family Child Care  
\_\_\_\_\_  
Address Amount Paid: \_\_\_\_\_  
\_\_\_\_\_  
City, State Zip Check No.: \_\_\_\_\_

**NOTICE: To insure prompt processing of your family child care relicensing application, please enclose the required fees along with all background releases, as well as all other required documentation.**

**Family Systems Licensing Application**  
 Minnesota Statutes, Chapter 245A (Human Services Licensing Act)  
**FAMILY Child Care (FCC)**  
 Minnesota Department of Human Services  
 Licensing Division  
 Office of Inspector General

**Date of Application:** \_\_\_\_\_

Please type or neatly print using black or blue ink. If you do not currently have a license from DHS, you must complete all items on the license application.

**1. License Type:**

- Individual - the site where services are provided is your primary residence.
- Individual - the applicant is the primary provider of care and the site where services are provided is not your primary residence.
- Individual – the applicant is the primary provider of care and the site where the services are provided is located in a commercial space. (Required documentation for Family Child Care provided in a Commercial Space must include a narrative description of the program, a copy of the compliance with local zoning regulations, AND a copy of the completed Fire Code Inspection designating what type of inspection was completed (Group E. or Group I-4), and of compliance with all Fire Marshal inspection orders.) **This information must be provided at initial application only.**

**Check One:**  New Application **OR**  Renewal

**2. License History:** Are you currently or have you ever been licensed?  YES (complete below)  NO

|  |                       |                            |
|--|-----------------------|----------------------------|
| Type of License (check all that apply)   |                       |                            |
| <input type="checkbox"/> Family Child Care <input type="checkbox"/> Child Foster Care <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Family Adult Day Services <input type="checkbox"/> Other _____ |                       |                            |
| License Number   | County/ Agency/ State | Effective Dates of License |
|  |                       |                            |

**2.1 Have you ever had a DHS license denied or revoked?**  Yes  No

If yes, list the date of denial or revocation and license type or the license number(s)

|                            |   |
|----------------------------|---|
| DATE OF LICENSE DENIAL     | LICENSE TYPE FOR DENIED LICENSE           |
| DATE OF LICENSE REVOCATION | LICENSE TYPE & NUMBER FOR REVOKED LICENSE |

*\*\* For additional denials or revocations, please attach additional pages*

**3. License holder information**

**3.1 License holder name(s)/Controlling Individual(s)/Authorized Agent(s)**

The license holder is the business entity that is responsible for the license. An "individual" license holder is generally a **sole owner** or **sole proprietorship** where the business is owned and run by one individual and in which there is no legal distinction between the owner and the business. This means you have not formed a corporation (e.g., business, for profit, nonprofit, limited liability corporation) and have not organized as a partnership, association, other organization and are not a government entity. You may have registered with the Minnesota Secretary of State's office

to use an assumed name, and you may have employees, but you are still a sole owner/sole proprietor. Two or more individuals may be co-applicants or co-license holders if they are not a corporation, partnership, voluntary association, or other organization or government entity. All individual license holders and applicants are also the controlling individuals as defined under section 245A.02, subdivision 5a, and authorized agents as required by section 245A.04, subdivision 1 (b). Attach additional pages if needed.

|  |        |               |                  |
|--|--------|---------------|------------------|
| Full Legal Name of Applicant/Controlling Individual/Authorized Agent |        |               |                  |
| Street Address (PO Box is not acceptable)                            |        | Email Address | Telephone Number |
| City   | County | State         | Zip Code         |

|  |        |               |                  |
|--|--------|---------------|------------------|
| Full Legal Name of Applicant/Controlling Individual/Authorized Agent |        |               |                  |
| Street Address (PO Box is not acceptable)                            |        | Email Address | Telephone Number |
| City   | County | State         | Zip Code         |

**3.2 Tax identification information** (This information is not public):

You are required to provide your tax identification information, including your Federal Employer ID Number (FEIN), if you have one.

You must provide your Minnesota Tax Identification 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 information on registering for a Minnesota Tax ID, go to the Minnesota Department of Revenue website. You must also provide your FEIN, if you have one. This is a nine-digit number you obtained 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 identification information is not public, except that under section 270C.72, DHS is required to provide the Minnesota Department of Revenue the tax identification number and the Social Security Number 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 identification 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 Internal Revenue Service.

|                             |  |  |
|-----------------------------|--|--|
| MN TAX ID (IF YOU HAVE ONE) | SSN(s) (FOR EACH <u>INDIVIDUAL</u> APPLICANT ) | FEDERAL EMPLOYER ID NUMBER (FEIN)<br>(IF YOU HAVE ONE) |
|-----------------------------|--|--|

**4. Program name and physical location**

Please enter the name and physical location of your program. The "Program Name" may be different from the license holder name.

|   |  |               |                  |
|---|--|---------------|------------------|
| Program Name                              |  |               |                  |
| Street Address (PO Box is not acceptable) |  | Email Address | Telephone Number |
| City                                      |  | State         | Zip Code         |

**5. Dwelling Information** (check all that apply)

- Single Family Home   
 Duplex/Twin home   
 Apartment/Condo   
 Townhome   
 Mobile Home   
 Other  
 Owned                   
 Rented                   
 Basement                   
 Second Floor                   
 Above Second Floor  
 Attached Garage       
 Wood Burning Stove/Fireplace

**6. All Children and Adults/Living and/or Working in the Program** (attach additional pages if needed)

| Name (Last, First, MI) | Relationship | Gender | Birth Date |
|------------------------|--------------|--------|------------|
| Name (Last, First, MI) | Relationship | Gender | Birth Date |
| Name (Last, First, MI) | Relationship | Gender | Birth Date |
| Name (Last, First, MI) | Relationship | Gender | Birth Date |
| Name (Last, First, MI) | Relationship | Gender | Birth Date |
| Name (Last, First, MI) | Relationship | Gender | Birth Date |
| Name (Last, First, MI) | Relationship | Gender | Birth Date |
| Name (Last, First, MI) | Relationship | Gender | Birth Date |

**7. References** (Required at initial licensure only)

|                               |                  |          |
|-------------------------------|------------------|----------|
| <b>Name (Last, First, MI)</b> |                  |          |
| Street Address                | Telephone Number |          |
| City                          | State            | Zip Code |

|                               |                  |          |
|-------------------------------|------------------|----------|
| <b>Name (Last, First, MI)</b> |                  |          |
| Street Address                | Telephone Number |          |
| City                          | State            | Zip Code |

|                               |                  |          |
|-------------------------------|------------------|----------|
| <b>Name (Last, First, MI)</b> |                  |          |
| Street Address                | Telephone Number |          |
| City                          | State            | Zip Code |

**8. Class of License** (check one)

| <b>Licensed Capacity</b>  | Adult | Total Capacity | Total under school age | Total infants and toddlers | Maximum # of infants |
|---|-------|----------------|------------------------|----------------------------|----------------------|
| <input type="checkbox"/> A-Family                                   | 1     | 10             | 6                      | 3                          | 2                    |
| <input type="checkbox"/> B1-Family (Specialized Infant and Toddler) | 1     | 5              | 3                      | 3                          | 3                    |
| <input type="checkbox"/> B2-Family (Specialized Infant and Toddler) | 1     | 6              | 4                      | 4                          | 2                    |
| <input type="checkbox"/> C1- Group Family                           | 1     | 10             | 8                      | 3                          | 2                    |
| <input type="checkbox"/> C2- Group Family                           | 1     | 12             | 10                     | 2                          | 1                    |
| <input type="checkbox"/> C3- Group Family                           | 2     | 14             | 10                     | 4                          | 3                    |
| <input type="checkbox"/> D- Group (Specialized Infant and Toddler)  | 2     | 9              | 7                      | 7                          | 4                    |

## 9. Hours of Operation

Open from the month of: \_\_\_\_\_ through the month of \_\_\_\_\_

### Daily Hours :

Monday \_\_\_\_\_

Friday \_\_\_\_\_

Tuesday \_\_\_\_\_

Saturday \_\_\_\_\_

Wednesday \_\_\_\_\_

Sunday \_\_\_\_\_

Thursday \_\_\_\_\_

## 10. Workers compensation insurance verification

You must complete and submit the Certificate of Compliance Minnesota Workers' Compensation Law (MN LIC 04) form with your license application in order for your application to be complete. Under section 176.182 DHS is prohibited from issuing a license until the applicant presents acceptable evidence of compliance with the workers' compensation insurance requirement of Minnesota Statutes, Chapter 176.

Minnesota workers' compensation law requires all employers to purchase workers' compensation insurance or become self-insured. This is often referred to as "mandatory coverage." Employers are generally defined as those who hire another to perform services. Employees are generally defined as people performing services for another, for hire, including minors and workers who are not citizens. For information on worker's compensation insurance requirements go to the Minnesota Department of Labor and Industry website at:

<http://www.dli.mn.gov/WorkComp.asp>.

## 11. Applicant acknowledgement of public funding reimbursement for licensed services

Under section 245A.04, subdivision 1, DHS license holders who elect to receive *any* public funding reimbursement, including Medical Assistance or Child Care Assistance, 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 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.

## 12. Applicant Agreement, Acknowledgement and Verification Form

All Applicant(s)/Controlling Individual(s)/Authorized Agent (s) named above in Section 3, must review and approve the license application before it is submitted to DHS, and must sign below only in the presence of a notary public. For more than one applicant, each applicant must complete a separate signatory page.

**\*Please note:**

- **Notarization is required at initial application for new applicants**
- **Notarization is required at the next relicensing date for existing license holders**
- **Notarization is only required ONE TIME, and is not needed for subsequent applications at relicensing**

By signing below, I agree that the information that I have provided on this application form is true, accurate and complete. If the Commissioner of Human Services grants me a license, I agree to comply with the requirements contained in Minnesota Statutes, chapter 245A and all applicable laws and rules, at all times during the terms of the license. I acknowledge that the Commissioner's representative 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. Further, I acknowledge that the documentation and inspection required by statutes and rules is necessary for the Commissioner to determine whether I am complying with Minnesota Rules and Laws. Finally, I understand that the Commissioner may fine, suspend, revoke or make conditional, or deny a license if an applicant or a 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 the Commissioner in connection with an application for a license or during an investigation.

In accordance with Minnesota Statutes, section 245A.04, subdivision 1, by signing your name you are affirming that you are the individual applicant or the authorized agent for the nonindividual applicant, responsible for dealing with the Commissioner of Human Services on all matters provided for in Minnesota Statutes, Chapter 245A and on whom service of all notices and orders must be made.

I, \_\_\_\_\_ (print full legal name), being sworn, state that I am the authorized agent for the license holder identified above. I understand that, by signing below, I am responsible for dealing with the commissioner of human services on all matters provided for in Minnesota Statutes, chapter 245A. I also understand that service of all notices and orders affecting any license held by the License Holder identified above may be made on me, in accordance with Minnesota Statutes 2012, section 245A.04, subdivision 1.

Subscribed and sworn to before me on  
this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Signature of Authorized Agent  
(WAIT- SIGN ONLY IN FRONT OF A NOTARY PUBLIC)

# Certificate of Compliance Minnesota Workers' Compensation Law

**THIS FORM MUST BE COMPLETED BY THE BUSINESS LICENSE APPLICANT**

**PRINT IN INK or TYPE**

Minnesota Statutes §176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes Chapter 176. If the required information is not provided or is falsely stated it shall result in a \$2,000 penalty assessed against the applicant by the commissioner of the Department of Labor and Industry.

A valid workers' compensation policy must be kept in effect at all times by employers as required by law.

|  |                           |                            |          |
|--|---------------------------|----------------------------|----------|
| License or certificate number (if applicable)  | Business telephone number | Alternate telephone number |          |
| Business name (Provide the legal name of the business entity. If the business is a sole proprietor or partnership, provide the owner's name(s), for example John Doe, or John Doe and Jane Doe.) |                           |                            |          |
| DBA ("doing business as" or "also known as" an assumed name), if applicable  |                           |                            |          |
| Business address (must be physical street address, no P.O. boxes)  | City                      | State                      | ZIP code |
| County   | Email address             |                            |          |

**YOUR LICENSE OR CERTIFICATE WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. *You must complete number 1 or 2 below.***

### Number 1 – Workers' compensation insurance policy information

|  |                |                 |
|--|----------------|-----------------|
| Insurance company name (not the insurance agent) | NAIC number    |                 |
| Policy number                                    | Effective date | Expiration date |

### Number 2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, call (651) 284-5032 or 1-800-342-5354.

- I have no employees. (See [Minnesota Statute § 176.011, subd. 9](#) for the definition of an employee.)
- I am self-insured for workers' compensation (attach a copy of the authorization to self-insure from the [Minnesota Department of Commerce](#)).
- I have employees but they are not covered by the workers' compensation law. (See [Minnesota Statute § 176.041](#) for a list of excluded employees.) Explain why your employees are not covered:  
  
\_\_\_\_\_

I certify the information provided on this form is accurate and complete. If I am signing on behalf of a business, I certify I am authorized to sign on behalf of the business.

**Print name**

|                                |       |      |
|--------------------------------|-------|------|
| Applicant signature (required) | Title | Date |
|--------------------------------|-------|------|

NOTE: You must notify the authority issuing your license if there is any change to your workers' compensation insurance information or an employee status change by resubmitting this form. This material can be made available in different forms, such as large print, Braille or audio.

Department of Human Services  
Office of Inspector General  
Licensing Division - Family Systems  
Family Child Care Licensing Checklist

|                                |  |                              |          |
|--------------------------------|--|------------------------------|----------|
| NAME (Last, First, MI)         |  | DATE COMPLETED               |          |
| ADDRESS                        |  | EMAIL                        |          |
| CITY                           |  | STATE                        | ZIP CODE |
| CO-APPLICANT (Last, First, MI) |  | (AREA CODE) TELEPHONE NUMBER |          |

**PROGRAM (9502.0415)**

1. Describe a typical day in child care (include creative activities, TV/video, outdoor play, reading) (9502.0415, subpart 1.)

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2. What type of structured activities do you do with the children? (9502.0415, subpart 1, 4, 6, 8, 10)

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3. Are activities scheduled indoors and outdoors, weather permitting? (9502.0415, subpart 1.A.)

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4. How is outdoor play supervised? (9502.0315, subpart 29.A. and 9502.0365, subpart 5)

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**PHYSICAL ENVIRONMENT AND SAFETY FACTORS (9502.0425)**

1. List all the rooms used for child care. (9502.0425, subpart 1) \_\_\_\_\_

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For initial licensing: Approved floor plan with square footage attached.

2. Have you done any remodeling to your home since your last renewal?  YES  NO  
If yes, describe (example: room addition, patio, deck) (9502.0425, subparts 14 & 15) \_\_\_\_\_

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3. If there have been any additions or remodeling, do these areas have at least two means of escape? (9502.0425, subpart 4)  YES  NO  N/A

|                    |
|--------------------|
| <b>WORKER ONLY</b> |
|                    |

If one exit is a window, does it:

- a) Open without special knowledge, and  YES  NO  N/A
- b) Have a clear opening of at least 5.7 square feet (with a minimum of 20 inches wide, a minimum of 24 inches high, and is it no more than 48 inches off the floor?)  YES  NO  N/A
- 4. If you have a deck, will this ever be used by children in care? (9502.0425, subpart 11)  YES  NO  N/A

If not used for child care, how is access prevented for children in care? \_\_\_\_\_  
\_\_\_\_\_

- Is the deck 30 inches or less above the ground? (9502.0425, subpart 11)  YES  NO
- Is there a guard? (9502.0425, subpart 11)  YES  NO

How high is the guard rail? (9502.0425, subpart 11) \_\_\_\_\_  
Is it enclosed properly? (9502.0425, subpart 11)  YES  NO

- 5. Is your basement used for childcare? (9502.0425, subpart 1. B)  YES  NO  N/A
- If yes, do you have two means of escape that meet fire code? (9502.0425, subpart 4)  YES  NO

How is your furnace/water heater/workshop area(s) separated from the play area? (9502.0425, subpart 7 E)  
\_\_\_\_\_  
\_\_\_\_\_

- 6. Are all stairways, both indoors and outdoors, with three or more steps equipped with handrails? (9502.0425, subpart 10.A)  YES  NO  N/A
- Is the area between the handrail and the stair tread enclosed properly? (9502.0425, subpart 10. B)  YES  NO  N/A
- Is the back of the stair riser enclosed? (9502.0425, subpart 10. B)  YES  NO  N/A
- Do you have a gate, barrier, or door on your stairways for children between 6 and 18 months of age? (9502.0425, subpart 10.C)  YES  NO  N/A

- 7. Do you have a fire extinguisher with a minimum rating of 2A10BC located near the kitchen? (9502.0425, subpart 16)  YES  NO
- Is it operational? (9502.0425, subpart 16)  YES  NO
- Do you know how to use it? (9502.0425, subpart 16)  YES  NO
- When was it last serviced? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MO/DAY/YR)

- 8. Do you have a working smoke detector located on each floor? (9502.0425, subpart 17)  YES  NO
- When were they last tested? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MO/DAY/YR)

- 9. Are all gas, coal, wood, kerosene or oil heaters, fireplaces, wood burning stoves, space heaters, steam radiators, and furnaces installed in accordance with the state building code? (9502.0425, subpart 7. A, B, and D)  YES  NO
- Are combustible items kept at least 36 inches from the furnace or other heating sources? (9502.0425, subpart 7. C)  YES  NO

Are all wood burning stoves, fireplaces, space heaters, radiators, and other hot surfaces protected so children do not have access to them when in use?  YES  NO  
(9502.0425, subpart 7. D)

10. Are emergency telephone numbers posted near the phone? (9502.0435, subpart 8)  
 911  YES  NO  
 Poison Control  YES  NO  
 Do you have an emergency substitute?  YES  NO  
 Name of emergency substitute \_\_\_\_\_

11. Are all toxic or hazardous materials kept out of reach?  YES  NO  N/A  
(9502.0435, subpart 4 and 6)

12. List location of the following items, indicating if area is locked, and how these items or area will be inaccessible to children in care. (9502.0435, subpart 4 and 6)

Medicines & vitamins \_\_\_\_\_ Matches & lighters \_\_\_\_\_

Sharp knives \_\_\_\_\_ Cleaning supplies \_\_\_\_\_

Plastic bags/wrap \_\_\_\_\_ Scissors \_\_\_\_\_

Sewing equipment \_\_\_\_\_ Alcoholic Beverage \_\_\_\_\_

Personal Care Items \_\_\_\_\_ Tools \_\_\_\_\_

Other toxic or hazardous items \_\_\_\_\_ Poisonous Plants \_\_\_\_\_

13. Do you have any firearms & ammunition in your home or on your property?  YES  NO  
(9502.0435, subpart 5) **These must be locked and stored in separate areas.**

If yes, where do you store you firearms? \_\_\_\_\_

Where do you store the ammunition? \_\_\_\_\_

14. Do you have the following items in your first-aid supplies? (9502.0435, subpart 7)

|                    |                              |                             |                     |                              |                             |
|--------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| Sterile compresses | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Ice pack/ cold pack | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thermometer        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | First-aid manual    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bandages           | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Scissors            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Tape               | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Mild Liquid Soap    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

15. Can your bathroom be opened from the outside if locked, and is the unlocking device near the door?  
(9502.0425, subpart 12. B)  YES  NO

16. Do you have a swimming pool used by children in care?  YES  NO  
(9502.0425, subpart 3)

If yes, are you complying with MN Statutes, Section 245A.14, subdivision 11?  YES  NO

Do you have a wading pool used by children in care?  YES  NO  
(9502.0425, subpart 3)

If yes, are you complying with MN Statutes, Section 245A.14, subdivision 10?  YES  NO

**NOTE: How is the pool inaccessible when not in use? (9502.0425, subpart 3)** \_\_\_\_\_

\_\_\_\_\_

17. If you use a swimming pool or a beach, is the attendant present trained in first aid and resuscitation?  
(9502.0425, subpart 3)  YES  NO

18. Do you live on a high traffic street or highway, near water, or near railroad tracks?  
(9502.0425, subpart 2)  YES  NO

If yes, circle all that apply: High traffic street or highway      Near water      Near railroad tracks

19. Is your yard fenced?  YES  NO

**SANITATION AND HEALTH (9502.0435)**

1. Are garbage containers and rubbish inaccessible to infants and toddlers?  
(9502.0435, subpart 3)  YES  NO

Where do you keep your garbage and rubbish containers? (9502.0435, subpart 3)

Indoors \_\_\_\_\_

Outdoors \_\_\_\_\_

2. Do you have any pets? (9502.0435, subpart 12)  YES  NO

If yes, what type of pet(s) do you have? \_\_\_\_\_

Date of last rabies shot for dogs and cats (9502.0435, subpart 12. C) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Expiration date of shots: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_/\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Where are pet cages/litter boxes located? \_\_\_\_\_

Are they away from food preparation, food storage or serving areas?  
(9502.0435, subpart 12. D)  YES  NO  N/A

Are birds clear of the bacteria chlamydia-psittaci? (9502.0435, subpart 12)  YES  NO  N/A

Is the play area free of animal excrement? (9502.0435, subpart 12. E)  YES  NO  N/A

3. Have there been any animal bites since your last renewal?  
(9502.0435, subpart 12. F and G)  YES  NO  N/A

If yes, were parent and health officials notified on the same day?  
(9502.0435, subpart 12. F)  YES  NO  N/A

4. Are separate towels, washcloths, cups, combs, and other personal articles used for each child?  
(9502.0435, subpart 10)  YES  NO

5. Are children's hand washed with soap and water when soiled, after use of a toilet or training chair, and before eating? (9502.0435, subpart 15)  YES  NO

6. Are diapers and clothing kept clean and dry and changed when wet or soiled?  
(9502.0435, subpart 13. B)  YES  NO  N/A

Where do you change diapers? (9502.0435, subpart 13. D) \_\_\_\_\_

\_\_\_\_\_

Do you use a washable, non-absorbent surface? (9502.0435, subpart 13. D)  YES  NO  N/A

If yes, describe \_\_\_\_\_

Do you wash this surface with a solution of soap and water if it is soiled? (9502.0435, subpart 13. D)  YES  NO  N/A

If yes, describe \_\_\_\_\_

Do you disinfect this surface with a solution of chlorine bleach and water after each diaper change? (2 teaspoons of bleach to 1 quart of water) (9502.0435, subpart 13. D)  YES  NO  N/A **OR**

Do you disinfect this surface with some other type of surface disinfectant after each diaper change? (245A.148)  YES  NO  N/A

If yes, name product \_\_\_\_\_

If yes, does the manufacturer's label or instructions state that the product is registered with the US Environmental Protection Agency?  YES  NO  N/A

If yes, does the manufacturer's label or instructions state that the disinfectant is effective against Staphylococcus Aureus, Salmonella Choleraesuis, and Pseudomonas Aeruginosa?  YES  NO  N/A

If yes, does the manufacturer's label or instructions state that the disinfectant is effective with a ten minute or less contact time?  YES  NO  N/A

If yes, does the manufacturer's label or instructions clearly state directions for mixing and use?  YES  NO  N/A

If yes, is the disinfectant used only in accordance with manufacturer's directions?  YES  NO  N/A

If yes, does the product NOT include triclosan or derivatives of triclosan?  YES  NO  N/A

Are soiled cloth diapers (except for a diaper service), plastic pants, and clothing placed in a plastic bag and sent home with the parents daily? (9502.0435, subpart 13. F)  YES  NO  N/A

Are children washed with a single-service disposable wipe or clean cloth before rediapering? (9502.0435, subpart 13. E)  YES  NO  N/A

Where are soiled diapers placed? (9502.0435, subpart 13. C) \_\_\_\_\_

Is this inaccessible to children and emptied when full (at least once daily)? (9502.0435, subpart 13. C)  YES  NO  N/A

Are clean diapers inaccessible to children? (9502.0435, subpart 13. A)  YES  NO  N/A

Are all cloth diapers labeled with the child's name? (9502.0435, subpart 13. A)  YES  NO  N/A

7. Do you or any caregiver or helper wash hands with soap and water after each diaper change, after assisting a child on the toilet, after washing the diapering surface, and before food preparation? (9502.0435, subpart 15)  YES  NO  N/A

Do you use a single-use towel to dry your hands? (9502.0435, subpart 15. B)  YES  NO

8. Are toilet-training chairs, stools, and seats washed with soap and water when soiled or at least daily? (9502.0435, subpart 14)  YES  NO

9. How many of each of the following do you have for child care use? (9502.0415, subparts 5, 7, and 9)

Cribs \_\_\_\_\_ Mesh Sided Cribs \_\_\_\_\_ Playpens \_\_\_\_\_ Beds \_\_\_\_\_

Cots \_\_\_\_\_ Sleeping bags \_\_\_\_\_ Mats \_\_\_\_\_ Sofa \_\_\_\_\_

Where do you sleep infants? (245A.1435) Cribs \_\_\_\_\_ Mesh Sided Cribs \_\_\_\_\_ Other \_\_\_\_\_

If other, please explain \_\_\_\_\_

Have you completed the monthly crib safety inspection form for each crib in use? (245A.146)  YES  NO

Do you have documentation of the brand name and model number for each crib used by or accessible to children in care? (245A.146, subdivision 2)  YES  NO

Have you annually checked the crib brand name and model number against the US Consumer Product Safety Web site and taken appropriate actions regarding unsafe cribs? (245A.146, subdivision 3)  YES  NO

Have you conducted and documented, at least monthly, safety inspections for every crib used by, or accessible to children in care? (245A.146, subdivision 4)  YES  NO

**Provide documentation to your licensor**

All rigid sided full-size and non-full-size cribs used or accessible in my family child care program meet the December 2012 federal safety standards under the Code of Federal Regulations, title 16 part 1219 or part 1220.  YES  NO

Documentation of compliance for each crib is available and my licensor has verified it? **If NO, provide documentation to your licensor**  YES  NO

10. Do you place each infant under one year of age to sleep in the crib with items other than a pacifier? (245A.1435)  YES  NO

If yes, explain in more detail: \_\_\_\_\_

11. Do you place infants to sleep on their back? (245A.1435)  YES  NO

Do you place infants to sleep in any other position other than their back?  YES  NO

If yes, please explain: \_\_\_\_\_

If yes, do you have a signed physician directive for an alternative sleep position for the infant? (245A.1435)  YES  NO

Do you have any infants in care that independently roll onto their stomach after being placed to sleep on their back?  YES  NO

If yes and if the infant is not at least 6 months of age, do you have a signed statement from the parent indicating that the infant regularly rolls over at home?  YES  NO

If an infant falls asleep before being placed in a crib:

Do you move the infant as soon as practicable to a crib?  YES  NO

Do you keep the infant within sight until they are placed in a crib?  YES  NO

Please explain your practice: \_\_\_\_\_

Do you know that a sleeping infant must **not be** in a position where the airway may be blocked or with anything covering the infant's face?  YES  NO

12. Do you swaddle infants? (245A.1435)  YES  NO

If yes, do you have an informed written consent from the parent to do so?  YES  NO

**Provide documentation of consent to your licensor**

If yes, do you swaddle infants in a one piece sleeper equipped with an attached system that fastens securely only across the upper torso with no constriction of the hips or legs?  YES  NO

OR

Do you swaddle infants in a blanket?  YES  NO

Do you use other methods to swaddle infants?  YES  NO

If yes, please explain: \_\_\_\_\_

13. In-person checks are **encouraged** to monitor sleeping infants in care. (245A.147, subdivision 1)

Do you conduct in-person checks on sleeping infants throughout the hours of sleep every 15 minutes during the first four months of care?  YES  NO

For all other infants, do you conduct in person checks throughout the hours of sleep every 30 minutes?  YES  NO

Do you conduct in-person checks on sleeping infants throughout the hours of sleep every 15 minutes when an infant has an upper respiratory infection?  YES  NO

In addition to the in-person checks, do you use and maintain an audio or visual monitoring device to monitor each sleeping infant during all hours of sleep?  YES  NO  
(245A.147, subdivision 2)

If you use different methods of monitoring sleeping infants, please describe:  
\_\_\_\_\_

14. Is clean, separate bedding provided for each child in care? (9502.0435, subpart 11)  YES  NO

Do your crib sheets fit tightly so they overlap the underside of the mattress and cannot be dislodged by pulling on the corner of the sheet with reasonable effort? (245A.1435)  YES  NO

15. Is drinking water available and offered to children (including older infants) at frequent intervals? (9502.0445, subpart 1. B)  YES  NO

Are separate or single-service cups or bottles used? ( 9502.0442, subpart 1. B)  YES  NO

16. What do you use for a water supply for drinking, cooking, and/or food prep? (9502.0445, subpart 1. A)

- Municipal water supply
- Bottled Water
- Well water—if well water, what is the date of the most current test? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MO/DAY/YR)

**Have a copy of the well water test available for licensor.**

17. Is your water temperature at or below 120 degrees Fahrenheit? (9502.0435, subpart 15. A)  YES  NO

18. Do you use only pasteurized milk for children in care? (9502.0445, subpart 2)  YES  NO

19. Do you participate in the USDA Food Program? (9502.0445, subpart 3. A)  YES  NO

If yes, which one: \_\_\_\_\_

If no, do you provide the basic food groups? (9502.0445, subpart 3. A)  YES  NO  
**Provide a sample menu to your licensor.**

20. Are all foods, lunches, and bottles brought from home labeled with the child's name and refrigerated when necessary? (9502.0445, subpart 3. D)  YES  NO

Is refrigerator no more than 40 degree F? (9502.0445, subpart 4. B)  YES  NO

Are bottles washed after use? (9502.0445, subpart 3. D)  YES  NO

**MISCELLANEOUS SAFETY**

1. Are electrical outlets covered in the areas of your home which are used by the children in care under first grade? (9502.0425, subpart 18. A)  YES  NO

2. Do you use extension cords as a substitute for permanent wiring? (9502.0425, subpart 18. C)  YES  NO

3. Do you transport children in care in your vehicle? (9502.0435, subpart 9)  YES  NO

If so, have you received training on child passenger restraint systems? (245A.50, subdivision 6)  YES  NO

Date training received: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MO/DAY/YR)

Do you have written permission from parents to transport children in care? (9502.0435, subpart 9. D)  YES  NO

Do you comply with all seat belt and child passenger restraint systems required under section 169.685? (245A.18, subdivision 1)  YES  NO

Are all other children securely fastened in seat belts? (9502.0435, subpart 9. A)  YES  NO

Is your vehicle licensed according to state law? (9502.0435, subpart 9.C)  YES  NO

Does the driver of the vehicle hold a current valid driver's license? (9502.0435, subpart 9.C)  YES  NO

**NOTE: Children may not be left unattended in any vehicle.** (9502.0435, subpart 9. E)

4. Is your child care license posted in a prominent place? (9502.0335, subpart 10)  YES  NO

If yes, where is it posted? \_\_\_\_\_

Are correction orders and negative actions received posted as required? (245A.06, subdivision 8 and 245A.07, subdivision 5)  YES  NO  N/A

Do you have an emergency exit plan on file? (9502.0435, subpart 8. F)  YES  NO

**LICENSE HOLDER TRAINING REQUIREMENTS**

1. List child care-related training you have taken since your last relicensing: (16 hours of training is required annually) ( 245A.50, subdivision 7)

**All approved training for applicants and providers can now be found at Develop located at [www.developtoolmn.org](http://www.developtoolmn.org) You can also register and keep track of your training, including training for other caregivers, and print out training records from the website to provide to your licensor.**

|   | Date | Hours |
|---|------|-------|
| <b>***New Applicants ONLY- You must complete the following required training prior to being licensed:</b>   |      |       |
| Child Growth and Development/Behavior Guidance (4 hours) (245A.50, subd. 2) also known as (AKA): "Developmentally Appropriate Behavior Guidance" listed at <a href="http://developtoolmn.org">developtoolmn.org</a> |      |       |
| Sudden Unexpected Infant Death (SUID – formerly SIDS) (if caring for infants) (245A.50, subd. 5) Available in-person or thru Eager to Learn   |      |       |
| Abusive Head Trauma (AHT – formerly SBS) (if caring for children under school age) (245A.50, subd. 5) Available in-person or thru Eager to Learn  |      |       |
| First Aid (245A.50, subd. 3)  |      |       |
| Cardiopulmonary Resuscitation (CPR) (245A.50, subd. 4)  |      |       |
| Child Passenger Restraint (if transporting children under 9) (245A.50, subd. 6)   |      |       |
| Supervising for Safety (6 hour course ONLY) (245A.50, subd. 9)  |      |       |

| Required License Holder Training  | Date | Hours |
|---|------|-------|
| Child Growth & Development/Behavior Guidance Training (required annually)( 245A.50, subd. 2) (formerly any Core Competency <b>IV</b> OR <b>I &amp; IV</b> course) <b>##</b> Any MN Knowledge & Competency Framework (KCF) Content Area 2C course listed at <a href="http://developtoolmn.org">developtoolmn.org</a> will meet <b>both</b> Child Growth & Development/Behavior Guidance Training.<br>Any KCF Content Area 1 course listed at <a href="http://developtoolmn.org">developtoolmn.org</a> will <b>ONLY</b> meet child growth & development An additional course under KCF Content Area 2C would need to be completed to meet both Child Growth & Development/Behavior Guidance Training. |      |       |
| Sudden Unexpected Infant Death (SUID – formerly SIDS) (every 2 years if caring for infants) (245A.50, subd. 5) Available in-person or thru Eager to Learn   |      |       |
| Abusive Head Trauma (AHT – formerly SBS) (every 2 years if caring for children under school age) (245A.50, subd. 5) Available in-person or thru Eager to Learn  |      |       |
| First Aid (required every 2 years)(245A.50, subd. 3)  |      |       |
| Cardiopulmonary Resuscitation (CPR)(required every 2 years) (245A.50, subd. 4)  |      |       |
| Child Passenger Restraint (required every 5 years if transporting children under 9) (245A.50, subd. 6)  |      |       |
| Supervising for Safety Training (2 hours)(required annually) (245A.50, subd. 9) AKA any "Active Supervision:" course listed at <a href="http://developtoolmn.org">developtoolmn.org</a>   |      |       |
| <b>Additional courses that comply with 245A.50, subd. 7 to ensure 16 hours completed</b>  |      |       |
|   |      |       |
|   |      |       |
|   |      |       |
|   |      |       |
| <b>**2nd Year Required Training. You must complete the following training annually:</b>   |      |       |
| Child Growth & Development/Behavior Guidance Training (required annually)( 245A.50, subd. 2) (formerly any Core Competency <b>IV</b> OR <b>I &amp; IV</b> course) <b>See ## above</b>   |      |       |
| Supervising for Safety Training (2 hours)(required annually) (245A.50, subd. 9) AKA any "Active Supervision:" course listed at <a href="http://developtoolmn.org">developtoolmn.org</a>   |      |       |
| Sudden Unexpected Infant Death (SUID- formerly SIDS) (required every 2 years if caring for infants)(245A.50, subd. 5)Available in-person or thru Eager to Learn <b>OR</b> SUID Videos (required on off year) (245A.50 subd. 5)  |      |       |
| Abusive Head Trauma (AHT – formerly SBS) (required every 2 years if caring for children under school age)(245A.50, subd. 5)Available in-person or thru Eager to Learn <b>OR</b> AHT Videos (required on off year) (245A.50 subd. 5, e)  |      |       |
| <b>Additional courses that comply with 245A.50, subd. 7 to ensure 16 hours completed</b>  |      |       |
|   |      |       |
|   |      |       |
|   |      |       |
|   |      |       |

**OTHER CAREGIVERS TRAINING REQUIREMENTS**

1. Will there be any adult caregivers working with you in your child care on a regular basis? (9502.0365, subpart 5)  YES  NO

If yes, name: \_\_\_\_\_

2. Have adult caregivers completed the required training? (see below)  YES  NO

3. For adult caregivers, 16 hours of training is required within one year of date of employment and annually thereafter.(245A.50, subd. 7) Helpers who assist with care on a regular basis must complete six hours of training within one year after the initial date of employment. (245A.50, subd.1. b)

| <b>***Other caregivers must complete the following training prior to providing care:</b>  | <b>Date</b> | <b>Hours</b> |
|---|-------------|--------------|
| Child Growth and Development/Behavior Guidance (4 hours) (245A.50, subd. 2) AKA: "Developmentally Appropriate Behavior Guidance" listed at <a href="http://developtoolmn.org">developtoolmn.org</a> |             |              |
| Sudden Unexpected Infant Death (SUID – formerly SIDS) (if caring for infants) (245A.50, subd. 5) Available in-person or thru Eager to Learn   |             |              |
| Abusive Head Trauma (AHT – formerly SBS) (if caring for children under school age) (245A.50, subd. 5) Available in-person or thru Eager to Learn  |             |              |
| First Aid (245A.50, subd. 3)  |             |              |
| Cardiopulmonary Resuscitation (CPR) (245A.50, subd. 4)  |             |              |
| Child Passenger Restraint (if transporting children under 9) (245A.50, subd. 6)   |             |              |
| Supervising for Safety (6 hour course ONLY) (245A.50, subd. 9)  |             |              |

**Other Caregiver Required Training**

|   | <b>Date</b> | <b>Hours</b> |
|---|-------------|--------------|
| Child Growth & Development/Behavior Guidance Training (required annually)( 245A.50, subd. 2) (formerly any Core Competency <b>IV</b> OR <b>I &amp; IV</b> course)<br><b>##</b> Any MN Knowledge & Competency Framework (KCF) Content Area 2C course listed at <a href="http://developtoolmn.org">developtoolmn.org</a> will meet <b>both</b> Child Growth & Development/Behavior Guidance Training.<br>Any KCF Content Area 1 course listed at <a href="http://developtoolmn.org">developtoolmn.org</a> will <b>ONLY</b> meet child growth & development. An additional course under KCF Content Area 2C would need to be completed to meet both Child Growth & Development/Behavior Guidance Training. |             |              |
| Sudden Unexpected Infant Death (SUID- formerly SIDS) (required every 2 years if caring for infants) (245A.50, subd. 5) Available in-person or thru Eager to Learn   |             |              |
| Abusive Head Trauma (AHT – formerly SBS) (required every 2 years if caring for children under school age) (245A.50, subd. 5) Available in-person or thru Eager to Learn   |             |              |
| First Aid (required every 2 years) (245A.50, subd. 3)   |             |              |
| Cardiopulmonary Resuscitation(CPR)(required every 2 years)(245A.50, subd. 4)  |             |              |
| Child Passenger Restraint (required every 5 years if transporting children under 9) (245A.50, subd. 6)  |             |              |
| Supervising for Safety Training (2 hours)(required annually) (245A.50, subd. 9) AKA any "Active Supervision:" course listed at <a href="http://developtoolmn.org">developtoolmn.org</a>   |             |              |
|   |             |              |
|   |             |              |
| <b>**2nd Year: All caregivers must complete the following required training annually:</b>   |             |              |
| Child Growth & Development/Behavior Guidance Training (required annually)( 245A.50, subd. 2) (formerly any Core Competency <b>IV</b> OR <b>I &amp; IV</b> course)<br><b>See ## above</b>  |             |              |
| Supervising for Safety Training (2 hours)(required annually) (245A.50, subd. 9) AKA any "Active Supervision:" course listed at <a href="http://developtool.mn.org">developtool.mn.org</a>   |             |              |
| Sudden Unexpected Infant Death (SUID-formerly SIDS)(required every 2 yrs if caring for infants)(245A.50, subd. 5) Available in-person or thru Eager to Learn <b>OR</b>  |             |              |
| SUID Videos (required on off year) (245A.50 subd. 5, e)   |             |              |
| Abusive Head Trauma (AHT– formerly SBS)(required every 2 yrs if caring for children under school age)(245A.50, subd. 5)Available in-person or thru Eager to Learn <b>OR</b>   |             |              |
| AHT Videos (required on off year) (245A.50 subd. 5, e)  |             |              |

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |

4. For any adult caregiver providing care on a regular basis, is there a physical examination record on file with the agency? (9502.0355, subpart 2. A & B)  YES  NO

5. Is there a background study on file with the agency? (245A.04, subdivision 3)  YES  NO

6. Do you use a substitute? (9502.0365, subpart 5)  YES  NO

**NOTE: Substitutes may not be used more than 30 days within any 12 month period**

If yes, how often? \_\_\_\_\_

If yes, is there a background study on file with the agency? (245A.04, subdivision 3)  YES  NO

Have they completed the required training?

a. Sudden Unexpected Infant Death -SUID (if caring for infants)  YES  NO

b. Abusive Head Trauma – AHT (if caring for children under school age)  YES  NO

7. Do you use a helper? (13-18 years of age) (9502.0315, subpart 14)  YES  NO

**NOTE: Children may not be left alone in the care of anyone under age 18.**

Have they completed the required training?

a. Sudden Unexpected Infant Death -SUID (if caring for infants)  YES  NO

b. Abusive Head Trauma – AHT (if caring for children under school age)  YES  NO

8. In the event of an emergency, vacations or holidays, do you have a substitute who is at least 18 years of age? (9502.0405, subpart 3. L)  YES  NO

Describe your emergency plan: \_\_\_\_\_  
 \_\_\_\_\_

**SUPERVISION**

1. Is the caregiver within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver is capable of intervening to protect the health and safety of children in care? (9502.0315, subpart 29. A and 9502.0365, subpart 5)  YES  NO

2. Is the caregiver available for assistance and care for school age children in care? (9502.0315, subpart 29. A and 9502.0365, subpart 5)  YES  NO

**BEHAVIOR GUIDANCE**

1. What kind of discipline is used with the children in care? (9502.0395, subpart 1 & 2)

Infants \_\_\_\_\_

Toddlers \_\_\_\_\_

Preschoolers \_\_\_\_\_

Schoolagers \_\_\_\_\_

**Review the following statements regarding behavior guidance and check the appropriate box at the end of the section.**

- **Corporal punishment** (physical discipline) is not allowed with the children in care. This includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking. (9502.0395, subpart. 2. A)

- **Emotional or psychological abuse** of the children in care is not allowed. This includes but is not limited to name calling, ostracism, shaming, derogatory remarks about the child or child's family, threats that threaten, humiliate or frighten the child. (9502.0395, subpart. 2. A)
- **Food, light, warmth, clothing, or medical care shall not be withheld** from a child. (9502.0395, subpart. 2. B)
- **Discipline and punishment shall not be delegated to another child.** (9502.0395, subpart. 2.C)
- **The separation of a child from a group to guide behavior** must be appropriate to the age of the child and circumstances requiring the separation. (9502.0395, subpart. 2. D)
- **An infant shall not be separated** from the group for disciplinary reasons. (9503.0395, subpart. 2. E)
- **A child shall not be separated** from the group for a period longer than 10 minutes. (9502.0395, subpart. 2. F)
- **A child separated** from the group must be placed in an area or separate room that is well lighted, free from hazards, ventilated, and open to the view of caregivers. (9502.0395, subpart. 2.G.)
- **No child shall be placed in a locked room to separate the child from the group.** (9502.0395, subpart. 2. H)
- **No child is to be punished for toileting accidents.** (9502.0395, subpart. 3. A. and B.)

I understand these statements and will abide by them.  YES  NO

I do not understand these statements and would like to discuss them with a licensor.  YES  NO

2. Do you discuss with the parents your child-rearing, sleeping, feeding, and behavior guidance practices? (9502.0405, subpart 1)  YES  NO

3. Describe your methods of toilet training: (9502.0405, subpart 4. B) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BE PREPARED TO SHOW VERIFICATION OF THE FOLLOWING:**

**INSURANCE**

1. Do you carry child care liability insurance? (245A.152)  YES  NO

If yes, do you inform parents in writing that a current certificate of coverage is available for inspection that includes the date of expiration or next renewal of the policy?  YES  NO

If no, do you provide an annual notice to parents that you do not carry any liability insurance? (245A.152)  YES  NO

**Provide documentation of the notice with parent signatures to your licensor.**

**PROVIDER RECORDS, POLICIES, AND REPORTING**

1. Do you have daily attendance records for each child for which you are reimbursed by a government program (i.e. CCAP, Early Learning Scholarship)? (245A.14, subdivision 14)  YES  NO  NA

2. Do the attendance records include the child's first/last name and the time the child was dropped off and the time the child was picked up? (245A.14, subdivision 14)  YES  NO  NA

**Provide documentation of the attendance records to your licensor.**

3. Do you have the following completed forms for each child on file in care? (9502.0405)

- Admission and Arrangement forms (subpart 4. A)  YES  NO
- Immunization Records (subpart 4. A & C)  YES  NO
4. Do you have written provider policies available for discussion with parents or agency? (9502.0405, subpart 3.)  YES  NO
5. Do you have an up-to-date Fire and Storm Drill Log? (9502.0405, subpart 3.H.)  YES  NO
6. Do you have an operable telephone located within the residence? (9502.0435, subpart 8. A)  YES  NO
7. Do you have an operable flashlight and battery-operated radio or TV? (9502.0435, subpart 8. E)  YES  NO
8. For what ages are your toys and play equipment suited? (9502.0415, subpart 3 & 9502.0435, subpart 4)
- 
9. Are they safe, in good repair, and free of lead-based paint?  YES  NO
- Is your supply adequate for the number and ages of children in care?  YES  NO
10. Have you had any fires requiring the service of a fire department since you last licensing visit? (Must be reported within 48 hours) (9502.0375, subpart 2.C)  YES  NO
11. Have you had a serious injury (needing treatment by a doctor) or death of a child in care since your last licensing visit? (Must be reported immediately.) (9502.0375, subpart 2. D)  YES  NO
12. Have you had any suspected cases of physical or sexual abuse or neglect? (Must be reported immediately) (9502.0375, subpart 2. B)  YES  NO
- Was the abuse/neglect reported?  YES  NO
13. Have there been any changes in the regular membership of your household? (9502.0375, subpart 2. A)  YES  NO
- If yes, have these changes been reported to the agency? (MN Statutes 245A.04, subdivision 3)  YES  NO
14. Have you documented the date you initiated a background study on a new caregiver and the date the new caregiver has direct contact with persons served by the program in their personnel file? (MN Statutes 245A.04, subdivision 3)  YES  NO
- Provide documentation to your licensor.**
15. Have you or anyone in your household received treatment or counseling for chemical dependency, alcohol, or drugs or other related issues since your last licensing visit? (9502.0335, subpart 6. A)  YES  NO
- If yes, explain: \_\_\_\_\_
16. Have you or anyone in your household or employee been charged with or convicted of a felony or misdemeanor, or been involved in any court services for any reason since your last licensing visit? (9502.0335, subpart 6. D and MN Statutes 245C.05, subdivision 6(b))  YES  NO
- If yes, explain: \_\_\_\_\_
- Have you received information about the possible criminal history or maltreatment history of an individual who is subject of a background study? (245C.05, subdivision 6(b))  YES  NO
17. If yes, did you provide that information immediately to your licensor?  YES  NO
- If yes, explain: \_\_\_\_\_

18. Do you allow smoking in your home during the hours children are in your care?  YES  NO  
(MN Statutes 144.414, subdivision 2)

19. Do you permit smoking in your home outside of the hours you operate your family child care?  YES  NO

If yes, the license holder must disclose to parents or guardians of children cared for on the premise if the license holder permits smoking outside the hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.  
(MN Statutes, 144.414, subdivision 2)

20. Do you have a current alcohol and drug policy for your program?  YES  NO  
(245A.04, subdivision 1. c)

20 Do you have a current grievance procedure for your program?  YES  NO  
(245A.04, subdivision 1. d)

21. Do you have a current child care program reporting policy?  YES  NO  
(245A.145, subdivision 1)

If yes, have you provided this policy to all parents at time of enrollment?  YES  NO

List any special concerns you wish to discuss at the licensing visit or any resource materials you would like:

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### STATEMENT

I wish to be licensed for family child care. I agree to abide by the licensing standard under Minnesota Department of Human Services Child Care Licensing Rule 9502.0300-9502.0445, and Minnesota Statutes, Chapters 245A and 245C.

Finally, I agree that any documentation that I provide or representations that I make to the commissioner's representative during the time that I am licensed is accurate and that any misrepresentations or other violations of Minnesota Rules and Laws may result in immediate suspension, revocation, or conditional status of my license or denial of my application.

|                            |      |
|----------------------------|------|
| Signature of Applicant     | Date |
| Signature of Co- Applicant | Date |

### FOR STAFF USE ONLY

|               |          |
|---------------|----------|
| Date of Visit | Met With |
|---------------|----------|

**FOR STAFF USE ONLY**

Classification and Number Licensed for: \_\_\_\_\_

Describe, if any, restrictions and/or conditional use:

**BACKGROUND STUDIES**

| Applicant /License Holder | BCA | Social Services | Juvenile | Other (if reasonable cause 245C.08, subpart 3) |
|---------------------------|-----|-----------------|----------|--|
| 1.                        |     |                 |          |  |
| 2.                        |     |                 |          |  |
| Household Member          | BCA | Social Services | Juvenile | Other (if reasonable cause 245C.08, subpart 3) |
| 1.                        |     |                 |          |  |
| 2.                        |     |                 |          |  |
| 3.                        |     |                 |          |  |
| 4.                        |     |                 |          |  |
| 5.                        |     |                 |          |  |

**ANNUAL LICENSING EVALUATION (9502.0345, subpart 1. F)**

Comments by License Holder:

Comments by the Licensing Worker:

Licensors Signature:

Date:

## Enrollment Form

Please complete the following information for all children you have cared for over the last 12 months, whether they are still in care or not and whether they are full or part time. Evaluations will be sent to at least two of these parents. (9502.0367 and 9543.0040, subpart 2. B. (b))

Provider Name \_\_\_\_\_ Class of License \_\_\_\_\_

Licenser Name \_\_\_\_\_

### Worker Only

| Child's Name | Enrollment start & end date | Sex | Date of Birth | Infant | Toddler | Preschool | School age | Parent Name & Address with Zip Code | Phone Number (both work and home) | Days and Hours of Care | Current or Past | Medication permission | Liability Ins. Notice | A & A | Immunization | Parent Evaluation |
|--------------|-----------------------------|-----|---------------|--------|---------|-----------|------------|-------------------------------------|-----------------------------------|------------------------|-----------------|-----------------------|-----------------------|-------|--------------|-------------------|
| 1            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 2            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 3            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 4            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 5            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 6            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 7            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 8            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |

## Enrollment Form

Please complete the following information for all children you have cared for over the last 12 months, whether they are still in care or not and whether they are full or part time. Evaluations will be sent to at least two of these parents. (9502.0367 and 9543.0040, subpart 2. B. (b))

Provider Name \_\_\_\_\_ Class of License \_\_\_\_\_

Licensors Name \_\_\_\_\_

### Worker Only

| Child's Name | Enrollment start & end date | Sex | Date of Birth | Infant | Toddler | Preschool | School age | Parent Name & Address with Zip Code | Phone Number (both work and home) | Days and Hours of Care | Current or Past | Medication permission | Liability Ins. Notice | A & A | Immunization | Parent Evaluation |
|--------------|-----------------------------|-----|---------------|--------|---------|-----------|------------|-------------------------------------|-----------------------------------|------------------------|-----------------|-----------------------|-----------------------|-------|--------------|-------------------|
| 9            |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 10           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 11           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 12           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 13           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 14           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 15           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |
| 16           |                             |     |               |        |         |           |            |                                     |                                   |                        |                 |                       |                       |       |              |                   |



**AUTHORIZATION FOR RELEASE OF INFORMATION  
FROM THE BUREAU OF CRIMINAL APPREHENSION  
LOCAL LAW ENFORCEMENT AGENCIES AND COUNTY  
SOCIAL SERVICE AGENCIES**

As required by Minnesota Statute 245C Chisago County is required to conduct a background check on its service providers. By signing this release the application hereby authorizes the Bureau of Criminal Apprehension, Court Administration, Local Law Enforcement Agencies and Social Service Agencies in areas I live or have lived to release any information they have regarding arrests; investigations; and/or convictions of all criminal history conviction data, to include juvenile delinquency matters; or information regarding maltreatment assessments. This information may be released to the Minnesota Department of Human Services and to the Chisago County Department of Health & Human Services. The information will remain in the licensing file and will be classified as private material. The information will be used in connection with the evaluation for licensure and/or registration as a legal/legal non-licensed provider within one or more of the following program areas:

Provider Name \_\_\_\_\_ Case # \_\_\_\_\_  
(if applicable)

|   |  |
|---|--|
| <input type="checkbox"/> Family Foster Care   | <input type="checkbox"/> Relative Foster Care  |
| <input type="checkbox"/> Family Day Care Home | <input type="checkbox"/> Emergency License     |
| <input type="checkbox"/> Adult Foster Care    | <input type="checkbox"/> Supervised Visitation |
| <input type="checkbox"/> Visitation           | <input type="checkbox"/>                       |

|              |               |
|--------------|---------------|
| Requested by | Social Worker |
|--------------|---------------|

**Applicant please supply the following information:** Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First Full Middle Maiden

Other Names Known By: \_\_\_\_\_

Address:

Street City State Zip County

Drivers License: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address of services:

(If different from above) Street City State Zip County

Phone Number : \_\_\_\_\_

**Other addresses you have lived at in the past five years:**

|                            |  |                            |  |
|----------------------------|--|----------------------------|--|
| 1. Address<br>From:<br>To: |  | 3. Address<br>From:<br>To: |  |
| City / State<br>Zip Code   |  | City / State<br>Zip Code   |  |
| County                     |  | County                     |  |
| 2. Address<br>From:<br>To: |  | 4. Address<br>From:<br>To: |  |
| City / State<br>Zip Code   |  | City / State<br>Zip Code   |  |
| County                     |  | County                     |  |

Use additional sheet of paper if necessary.

By signing below, I acknowledge and fully understand:

- That the State of Minnesota and Federal privacy laws protect my records and that these records can be released only if I give my written permission or if the law(s) requires it.
- That I can refuse to sign this release, but that if I do, no one in my household/agency will be able to be authorized as a child/adult care provider for a family receiving [county and/or state funds including child care assistance](#).
- That I can cancel this release with written notice at any time, but that this cancellation will not affect information that has already been requested or released. If I cancel this release, it may prevent a member of my household/ organization from being authorized as a provider for a family receiving [county and/or state funds to include child care assistance](#).
- That this release does not authorize redisclosure to any person or entity other than those listed above. However, information disclosed under this release may be subject to redisclosure, including as may be required or authorized by law. Once information is provided to a person or entity other than those listed above, it is no longer protected by this release.

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**Parent/Guardian Signature (if minor)** **Date**

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**Applicant Signature** **Date**

THE EXPIRATION DATE OF THIS AUTHORIZATION SHALL BE ONE YEAR FROM THE SIGNATURE DATE.