State of Montana

Quality Assurance Division - Licensure Bureau
Child Care Licensing Program

Change(s) to a Child Care Facility

Name_____ Phone#_____

Email Address: _____

Date that the change is effective:_____ **PV#**_____

Name of Facility: _____

Physical Address _____

Mailing Address _____

Street City State/Zip

Change to: ☐ Registration status ☐ Name ☐ Address ☐ Age ☐ Overlap care
☐ Other _____

Change my registration status:

From status type: ☐ ***Family*** ☐ ***Group*** ☐ ***Center***

To status type: ☐ ***Family*** (max. 6 Children) ☐ ***Group*** (max.12 Children) ☐ ***Center*** (over 12 children, maximum number of children allowed vary)

Facility Name:
Old:_____ New:_____
Facility Physical Address:
Old:_____ New:_____
Mailing Address:
Old:_____ New:_____

Descriptive directions to the **new** facility:_____

_____

_____

Phone Number ☐ New ☐ Change (____)____-_____ ☐ **Home** ☐ Work ☐ **Other**

Children Age(s): Please list the ages of the children in your facility:

Old:_____ New:_____

Hours/Days of operation

Old: _____

New/Days and hours:_____

Number of own children, under the age of 6, that will be cared for at the facility**:** _____

Please mark the youngest and oldest age of children, you wish to provide care to:

0	1	2	3	4	5	6	7	8	9	10	11	12

Overlap Care:

Are you, or do you wish to be, certified for Overlap Care? ☐ Yes ☐No ☐ Already Approved.
If already approved, is the Overlap Times changing? ☐ Yes ☐No (If yes, please complete Overlap Form)

Day Care Location:

Is the day care located in your residence? ☐ **Yes** (complete the *Household Member* and the *Caregivers* table below). ☐ **No** (please complete the *Caregivers* table below).

Household Members - In the space provided below please include the name and birth date, of all persons presently living in the home, where day care will be provided. (Please include yourself, if you reside there)

Name	Relationship	Date Of Birth
1.		
2.		
3.		
4.		
5.		

Caregivers - Please list the names, address, and phone number of persons responsible for the direct care and supervision of the children in your facility. Please indicate whether they are "F" full or "PT" part time.

For NEW caregivers, please submit the completed following forms:

- Employee Information Form;
- Release of Information;
- Proof of MMR and Tetanus Diphtheria (within the last 10 years); and
- Proof of current Adult, Infant, and Child CPR and First Aid Certification.

PS	Name	Address	Status F - PT
1.			
2.			
3.			
4.			
5.			

Comments:

Sworn Statement

In Accordance with Section 52-2-701 through 52-2-741, Montana Code Annotated, I hereby request the issuance of a Child Care Center License on the basis of my affirmation of the following statements.

Please Check

- ☐ I have received and have read a copy of the State Regulations for Child Care Centers that include the supplemental regulations for Infant Care.
- ☐ I certify that I intend to remain in compliance with the licensing requirements for Child Care centers.
- ☐ I understand that I may not care for more children at any one time than are indicated by the Child Care license.
- ☐ I understand that any complaints about my licensed day care facility may be investigated by a representative of the Department, without prior notification.
- ☐ I understand that my Child Care Center facility may be visited at any time by the child's parent(s) orby a representative of the Department, and I will allow entry.
- ☐ If I move to another address or stop providing care to children I must notify the Department of Public Health and Human Services, Child Care Licensing Program.
- ☐ I understand that the name and address of my day care center will appear on a list that is maintained by the Department of Public Health and Human Services and made available to the public upon request.
- ☐ I will keep the necessary Insurance in force covering the total number of children I am caring for.

- ☐ I certify that I have adequate Public Liability and Fire Insurance for the purpose of conducting Child Care.
- ☐ I will provide the department with the names, addresses, phone numbers and the parents' name(s) for each child in my care whenever requested to do so by the department.

To the best of my knowledge, all information I have given to the Department of Public Health and Human Services and/or its authorized agents on this form is true and correct. I will supply true and correct information requested during all subsequent contacts.

X _____

Signature Date