Family Friends & Neighbor Child Care
New and Renewal
Application Instructions and Checklist

Family Friends and Neighbor (FFN) Application: Complete, and sign as applicable for a renewal or new FFN provider application. As a new provider, your application beginning license date starts when all your application information is received. Once your application has been approved or denied, a letter will be sent to you with instructions on how to submit your invoices. If you have questions regarding invoicing, contact the (CCR) Child Care Resources facility in your district.
http://dphhs.mt.gov/hcsd/ChildCare/ChildCareResourceandReferral.aspx

If you have questions or need additional forms or information, please visit our website located at:

http://dphhs.mt.gov/qad/Licensure/LBCCL/LCPapplication

Unless indicated, the following forms are required for the New and Renewal FFN application:

- **Family Association**: This form indicates the family that the FFN will be providing care for.

- **Statement of Health form:** To be completed by each person living in the Providers' home who is 18 years of age and older.

- **State of MT Release of Information (ROI) Form**: The Provider, and each person 18 years of age and older, living in the home, must complete and submit this form. An out-of-state CPS background check will be conducted in every state in which you lived in the past five years. The background check(s) will be requested, as applicable, by the FFN licensing technician. All out- of -state Child Protective Service check costs are the responsibility of the applicant.

- **FBI Release of Information** form for **Fingerprints**:
  - A FBI fingerprint back ground check is needed for **ALL NEW** applications. A FBI background check is required every five years and is required for all providers and household members 18 years of age or older. If a FBI background check was conducted within the past 5 years and you left Montana, and returned within those 5 years, a FBI background check will be conducted.
  - FBI Rolled Fingerprint (Cards) –The fingerprints can be obtained at the Child Care Resources; following is a link to the list of CCR locations: http://dphhs.mt.gov/hcsd/ChildCare/ChildCareResourceandReferral.aspx, the Sheriff's office or Police station. Agencies that provide fingerprinting services may charge over and above the fee to cover their own processing fees.

- Along with the FFN application, submit the fingerprint cards, and a check or money order, payable to the **MT. Department of Justice** for **$27.25 fee per set of fingerprints**

- Finger prints are not needed for the parent of the children you are providing care for.

- **Health and Safety Checklist**: Both the parent and provider's signature are required.
- **Medication Administration Attestation**: Medication Administration Attestation completed by the parent and the provider.
- **Immunization Certification Form**: Providers signature is required.
- **Tax ID Form**: a W9 is for payment purposes, and is required for all applicants. New applications require a completed W9. Upon renewal, only send a W9 if there is a change to your name, address, or you are requesting a direct deposit.
  - If you are requesting direct deposit, attach a voided check.
  - If care is provided in the parent's home, the parent (head of household), the person who is responsible to pay the FFN must complete the W-9.

Training requirements:

All on-line training courses are available at www.Childcaretraining.org

An access code is needed to enroll in the course(s) The **ACCESS CODE** is: **HCeibcTm**

HEALTH AND SAFETY OVERVIEW

- This four-hour on-line training, and is required for **all FFN providers**
- This training must be completed before the initial license is approved.

FFN FUNDAMENTALS

- The FFN Fundamentals course replaces the LCP Orientation course, and is required for **all FFN providers**.
- This class must be completed within 60 days of registration.

CPR/FIRST AID CERTIFICATION (hands-on)

- This training is required for non-relative care providers.
- Call your local Child Care Resource Center, local fire dept., etc. for class availability.

Please remit the completed application to:

DPHHS/QAD/FFN
2401 COLONIAL DR
PO BOX 202953
HELENA, MT 59620

Email: FFNPPROGRAM@MT.GOV
Phone: (406) 444-0597
Fax: (406) 444-1742

Family, Friend & Neighbor
RENEWAL Application

I am renewing my FFN child care provider registration. Choose one: I am providing child care in my home ☐ I am providing child care in the Parent's home (approved by Parent(s) case mgr.) ☐

The Family, Friend & Neighbor Child Care Provider, assumes responsibility for following the program rules and requirements, including penalties and repayment of any overpaid benefits.

1. Provider Information

Legal Name: Last, First, Middle _____

Residential Address: _____ City, State Zip Code

Mailing Address: Same as above ☐ _____

Tribal Affiliation: Yes, ☐ No ☐ If yes, which one? _____

Cell Number: _____ Other Ph. No.: _____

Email Address: _____

2. Abuse and Neglect

- Since your initial license, have you, the applicant, had a child removed from your home? No ☐ Yes ☐ If Yes, when did this happen? (dates)
- Since your initial license, have you been investigated for possible abuse or neglect by the Department, a child welfare agency or law enforcement in another state? No, ☐ Yes ☐ If yes, what are the child's name and your relationship to the child? Where and when did this happen?

3. Household Members

ALL individuals listed below, 18 years of age or older, must complete the following forms: Release of Information, Statement of Health, and if applicable, a FBI release of information and fingerprint card.

Household Member (s) Name Last, First, Middle	Date of birth	Age	How are the children related to you?
Provider:			
HHM:			
HHM:			
HHM:			
HHM:			
HHM:			

Family Friends & Neighbor
Child Care
Family Association

1. Provider Information

This is the Family, who the Friend & Neighbor Child Care Provider (FFN) will be providing child care. This is the family that is receiving the Best Beginning Scholarship.
Provider Name:
TANF: Are you included in the Parent's TANF financial grant: YES, ☐ NO ☐

2. Family Information

This is the family whose care is being provided by the FFN. This parent is receiving the Best Beginnings Child Care Scholarship, and is the head of household.			
Head of Household Parent (s)Name:	Case #:		
Address:	City/ County:		
If known, Case Worker name:	Parent Phone#:		
Are the children a sibling group? Yes ☐ No ☐ Name of Children (Last, First, Middle)	Date of Birth	Age	Relationship to you, the FFN.

Family, Friend & Neighbor

Certification Checklist

Initial each line as applicable for the Child Care Provider or Parent(s) Residence.

_____ I certify that I reside and will be providing care in my home and I agree that I am an independent contractor.

_____ I certify I certify that if I am providing care in the Parent's home, I will only provide care to the children of one family.

_____ I certify that I will be providing care less than 24 hours within the day.

_____ I certify that I will review the health and safety checklist for FFN providers with the parent.

_____ I certify that I will be the only person transporting children while in my care.

_____ I certify that I will only provide care to the child(ren) of one family or that I will only provide care to no more than two children from separate families.

_____ I certify that I will review and discuss with the parents the immunization record of the children in my care; or, review and discuss the waiver indicating parental choice not to immunize.

_____ I certify that I will examine the home for fire and safety conditions, for the presence of working smoke detector, for placement of a family fire escape plan and discuss the conditions with the parents.

_____ I certify that I will inform parent(s) that the state will NOT make payments until the provider's and parent's applications are approved.

_____ I certify that I am aware it is recommended that the applicant not provide care until a letter of approval is received.

_____ I certify that I will review the health and safety checklist for FFN providers with the parent.

_____ I confirm that neither I, nor anyone present in the home, have been investigated for any alleged harm or physical or sexual abuse to children or adults. If this statement is false, I am providing the information required below about where the investigation occurred:

I attest that the above statements are true and correct to the best of my knowledge.

I understand that if I provide inaccurate information or misrepresent information in writing or verbally on this application, throughout the application process, and while certified, my application may be denied.

_____ _____

Provider Signature Date

Family Friend & Neighbor Care
Health and Safety Checklist

Health and Safety issues should be considered when arranging for child care. Here are some topics a parent and child care provider may want to discuss. For more information regarding quality child care, contact your local Child Care Resource and Referral Agency. ** ***No corporal punishment may be inflicted.*** **

YES	NO	Answer each question by initialing the **YES OR NO box.**
☐	☐	Do parents have access to their children at all times?
☐	☐	Is the provider in good health?
☐	☐	Is the provider trained about basic health and safety issues?
☐	☐	Is the provider knowledgeable about child development issues?
☐	☐	Does the provider wash hands thoroughly, before and after diapering?
☐	☐	Does the provider wash hands thoroughly, before preparing food?
☐	☐	Has the provider received guidelines on how to "child-proof" the home?
☐	☐	Does the provider talk easily with the children and respond to their needs?
☐	☐	Does the emotional climate foster happiness and trust?
☐	☐	Does the provider offer learning opportunities to the children?
☐	☐	Are children's immunizations current?
☐	☐	Are emergency telephone numbers and parent telephone numbers posted?
☐	☐	Is the provider trained in First Aid and CPR?
☐	☐	Does the provider have an emergency medical authorization form signed by the parent?
☐	☐	Is a first aid kit available?
☐	☐	Are meals and snacks nutritious?
☐	☐	Is there a quiet comfortable place for naps?
☐	☐	Is the play equipment safe?
☐	☐	Is the homeclean?
☐	☐	Are the children exposed to smoking?
☐	☐	Are hazards inaccessible to children, inside and out?
☐	☐	Are electrical outlets covered?
☐	☐	Are heaters ventilated and screened?
☐	☐	Are poisonous substances out of reach of children?
☐	☐	Are smoke detectors in place and operational?
☐	☐	Is a fire extinguisher available?
☐	☐	Are firearms locked and inaccessible?
☐	☐	Are appropriate automobile restraints, such as car seats, used?

By signing below, I state that I have read, discussed and understand the above information

Parent Signature Date

Provider Signature Date

Family, Friend & Neighbor Care

Immunization Attestation

I, the Provider, certify that I am in compliance with policy 6-2 that states:

Children in the Family, Friends, and Neighbor Provider [FFN] care is required to have immunizations except:

- *If the child is being cared for by an approved relative (grandparents, great-grandparents, aunt or uncle);*
- *If the child is being cared for in their own home;*
- *If the child has a medical condition that contra-indicates immunization;*
- *If a medical exemption for immunizations is being claimed, a LCP/LCI Immunization Waiver form must be completed.*

☐ **One or more of the above criteria, required for the exception to have immunizations, has been met.**

I certify that (child's name) ---------- has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

I certify that (child's name) ---------- has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

I certify that (child's name) ---------- has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

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I certify that (child's name) ---------- has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

Provider Signature/Date

STATE OF MONTANA

Department of Public Health and Human Services

Family, Friend & Neighbor Child Care

Release of Information

Criminal, CPS, and Motor Vehicle Background Checks

1. Personal Information

I am the applicant ☐ **I am a member of the household** ☐ **Female** ☐ **Male** ☐

Legal Name:
Last, First, Middle _____

Maiden Name _____ Alias(s) _____

Date of Birth: _____ Marital Status _____ Race _____

SSN _____ DL# _____

Residential Address: _____

City: _____ County: _____ State: **MT**

Phone Number: _____ Email Address: _____

Tribal Affiliation: **Yes** ☐ No ☐ If yes, which one? _____

2. Past Residences

Out of state or tribal background checks, may be required. There may be an associated cost for those background checks. Please indicate if the residence is on an Indian Reservation.

Have you lived in another state in the past five years? Yes ☐ No ☐

Date: _____ City: _____ State: _____ Reservation: _____

Date: _____ City: _____ State: _____ Reservation: _____

Date: _____ City: _____ State: _____ Reservation: _____

Have you been convicted of, plead guilty to, or currently charged with a crime classified as an offense against any person or family? Yes ☐ No ☐ If "Yes," give details, including name of person, date, place and nature of the conviction and disposition:

Have you ever been named as a perpetrator in a Substantiated report of child or adult abuse or neglect (or exploitation of an adult)? Yes ☐ No ☐ If "Yes," Please explain:

Have you or any person living in the home been convicted of a crime involving, child or Elder abuse or neglect, including sexual abuse, physical assault, or other act of violence? Yes ☐ No ☐ If yes, please explain.

3. Authorization Statement and Signature

As part of the initial and subsequent annual application process, I do hereby authorize any law enforcement and/or protective services agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services.

I am aware that The State of Montana, Department of Public Health and Human Services, has requested confidential information, in accordance with 41-3- 205(3)(o), MCA as part of a review of my personal background in connection with said entity.

I am aware that Child and Family Services Division and, Department of Justice records may contain information that could adversely affect my Legally Certified Provider approval. These records will relate to criminal history records, as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.

_____

Signature/Date

Family, Friend & Neighbor Care

Medication Administration Attestation

The authority for the Medication Administration Attestation is MCA 52-2-736

I, ---------- the Provider, acknowledge that I have discussed with the parent about administering medication while their child or children are in my care. I will log the medication on a Medication Administration Log as given to the child or children while in my care.

I, ---------- the Parent, will sign a Medication Authorization form for each prescription and non-prescription medication to be given to my child or children while in the care of the provider.

By signing below, I state that I have read, discussed and understand the above information.

Provider Signature Date Parent Signature Date

Family, Friend & Neighbor Care

Statement of Health

Name:

Please check one of the boxes below:

- ◯ I am applying to be a FFN provider.
- ◯ I am the spouse of the applicant.
- ◯ I am a member of the applicant's household.

Applicants and household members must meet certain health requirements. As the agency responsible for approving FFN payment numbers, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.

I attest that I have no disabling chronic conditions; physical, mental, or emotional illness that would prohibit me from providing care to children.

COMMENTS:

Signature DATE

STATE OF MONTANA

Department of Public Health and Human Services

Family, Friend & Neighbor Child Care

Release of Information

Criminal, CPS, and Motor Vehicle Background Checks

1. Personal Information

I am the applicant ☐ **I am a member of the household** ☐ **Female** ☐ **Male** ☐

Legal Name:
Last, First, Middle _____

Maiden Name _____ Alias(s) _____

Date of Birth: _____ Marital Status _____ Race _____

SSN _____ DL# _____

Residential Address: _____

City: _____ County: _____ State: **MT**

Phone Number: _____ Email Address: _____

Tribal Affiliation: **Yes** ☐ No ☐ If yes, which one? _____

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Have you lived in another state in the past five years? Yes ☐ No ☐

Date: _____ City: _____ State: _____ Reservation: _____

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Have you been convicted of, plead guilty to, or currently charged with a crime classified as an offense against any person or family? Yes ☐ No ☐ If "Yes," give details, including name of person, date, place and nature of the conviction and disposition:

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COMMENTS:

Signature DATE