



Child Care Provider Information Sheet

As part of your enrollment through the Eligibility List into the subsidized child care program, we are required to have information on the provider you have selected for your child(ren). Early Care and Education (ECE) must have this information in order to process your enrollment packet. Please complete this form and return it to the assigned ECE staff person.

If you have not yet selected a provider, please go to Online Referrals (rrrcoe.nohosoftware.com/online_referrals) to search for a provider or contact Resource & Referral (R&R) at RandR@rcoe.us or 800-442-4927.

Parent/Guardian's Name: _____

Parent/Guardian's Address: _____

Child(ren)'s Name(s): _____

Child Care Provider Name: _____

Is your child already in care with this provider? Yes No

If no, please indicate the date you would like child care to begin: _____

Have you verified that this provider has space to serve your child? Yes No On the provider's wait list

Please note that parents are responsible for ensuring that the selected provider has a space available for the child(ren) needing services and the cost of care cannot be covered by ECE until the parent completes the enrollment process and the provider has received child care certificates authorizing the start of services.

For Licensed Child Care Providers:

Child Care License Number: _____ Provider Address: _____

Provider Email: _____ Provider Phone Number: _____

For Unlicensed Child Care Providers-Family, Friend, or Neighbor (FFN):

Please indicate provider relationship to the child by marriage, blood relation, or legal adoption:

Grandparent Aunt Uncle Not related Other relative: _____

Child Care Provider Date of Birth: _____ Provider Driver's License or State ID: _____

Child Care Provider Physical Address: _____

Address Where Child Care Will Take Place: _____

Provider Email: _____ Provider Phone Number: _____

Provider Languages Spoken: _____

Does FFN Provider Have Other Children In The Home? Yes No

For Office Use Only

- | | |
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| <input type="checkbox"/> Date Received: _____ | <input type="checkbox"/> Completed Trustline Application Sent to CA |
| <input type="checkbox"/> Family ID: _____ | <input type="checkbox"/> Provider ID: _____ |
| <input type="checkbox"/> Program: _____ | <input type="checkbox"/> APID Requested |
| <input type="checkbox"/> Out of County Provider Approved by PDS | <input type="checkbox"/> Input into CARE Completed |
| <input type="checkbox"/> In-Home Provider | <input type="checkbox"/> APID Received |
| <input type="checkbox"/> Guardian Check Completed | <input type="checkbox"/> All Required Documents Uploaded into CARE |
| <input type="checkbox"/> Megan's Law Check Completed | <input type="checkbox"/> Liaison Informed of First Day of Care |