



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Community Based Regulation Section

**Note: This Cover Letter/Check List
MUST BE RETURNED With Your Renewal Application**

Dear Operator:

The license for your child day care facility is due to expire shortly. Enclosed is a copy of the *Newly Revised* and simplified renewal package for relicensure of your child day care license. Make three (3) copies of your completed renewal packet. It is required that one completed packet be submitted to the Department of Public Health (DPH), **SIXTY (60) DAYS PRIOR TO THE EXPIRATION** date of your license. Send one copy to your local sanitarian or health director's office, and **retain one copy of the packet for your files at the facility with your complete initial licensing application.**

THE NON-REFUNDABLE LICENSING FEE of \$200.00 for a Center License or \$100.00 for a Group Day Care Home License and ALL required documents, MUST BE INCLUDED WITH YOUR RENEWAL PACKET OR IT CAN NOT BE PROCESSED. Please make your check payable to **Treasurer - State of Connecticut.**

A license cannot be issued for your child day care facility until Local Health Department approval is received by the Department stating that your facility meets the public health code requirements for licensure as a child day care center or a group day care home. Please note that a current fire marshal's certificate must be posted at the facility at all times. It is your responsibility to contact your local fire marshal and local health sanitarian immediately and arrange for these inspections and certificates for your child day care facility.

Please reply directly to:
Child Day Care Licensing Unit
Department of Public Health – Day Care
410 Capitol Avenue, MS #12 -DAC
P.O. Box 340308, Hartford, CT 06134-0308
1-800-282-6063 or 1-800-439-0437 or (860) 509-8045.

ALONG WITH THE APPLICATION YOU MUST INCLUDE:

- 1. Cover Letter/Check List Yes No
- 2. Fee Invoice and Check Yes No
- 3. Affidavit Yes No
- 4. Consultant Data Sheet & Copies of All Current Agreements (Attachment #11f) Yes No
- 5. Proof of Worker's Compensation Form Yes No
- 6. Copy of Worker's Compensation Insurance Certificate Yes No
- 7. Lead Water Test (Bacterial & Chemical if well) Yes No
- 8. Water Supply (Attachment #13b) Yes No
- 9. Staff Work Schedule Yes No
- 10. Please indicate the **date** you have sent a copy of this application to your Local Health Department_____/_____/_____ and **be sure to include verification of the Local Health Inspection upon completion of the Inspection.**

- Was the building/structure in which you provide or will provide child care constructed prior to 1979? Yes No
- If Yes,** have you had a full Comprehensive Lead Paint Inspection? Yes No
- If Yes,** date of full Comprehensive Lead Paint Inspection ____/____/_____



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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH Community Based Regulation Section

Child Day Care Licensing – Fee Invoice Form

The licensing fee is due with your application to obtain or renew a child day care license. **THE FEE IS NON-REFUNDABLE.**

Please complete items 1 through 10 of this form. If you have questions, call the licensing office at 1-800-282-6063, 1-800-439-0437 or (860) 509-8045. Make your payment by check or money order payable to: **TREASURER-STATE OF CONNECTICUT. Mail this form along with your payment and application to the Department of Public Health at the address on the bottom of this form.**

1. Name of Licensee or Applicant: _____
(Legal Operator)

2. Program Name: _____
(Applicable For Group/Center Only)

3. Program Location Address:
_____, CT _____
Street Address City/Town Zip Code

4. Program Phone Number: (____) _____ - _____ Program Fax Number: (____) _____ - _____

5. License #: _____ Expiration Date: ____/____/____
(For Relicensure Only) (For Relicensure Only)

6. Mailing Address (if different):
_____, CT _____
Street Address City/Town Zip Code

7. Program E-mail Address: _____

8. Enclosed Check/Money Order: \$ _____ Check #: _____ Check Date: ____/____/____

9. Social Security #: _____ - _____ - _____ or Federal Employer ID #: _____ - _____
(3 digits) (2 digits) (4 digits) (2 digits) (7 digits)

10. Payment is for the following type of license: (check one box below)

Child Day Care Center (Account #42431)	Group Day Care Home (Account #42431)	Family Day Care Home (Account #42431)
<input type="checkbox"/> 6-month license (new program) \$50.00	<input type="checkbox"/> 6-month license (new program) \$30.00	<input type="checkbox"/> 2-year license (new provider) \$20.00
<input type="checkbox"/> 2-year license (relicensure) \$200.00	<input type="checkbox"/> 2-year license (relicensure) \$100.00	<input type="checkbox"/> 2-year license (relicensure) \$20.00



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**CT Department of Public Health
Community Based Regulation Section
Consultant/ Head Teacher Data Sheet**

(Attachment 11f)

**PLEASE PRINT - Please enter complete information for each Consultant and Head Teacher.
Enter N/A (not applicable) for questions that do not apply**

CURRENT AGREEMENTS FOR ALL CONSULTANTS MUST BE SUBMITTED WITH THIS FORM
--

Name of Person completing this form: _____

Position: _____ Date form completed: _____

Program Name: _____ License # _____

Street Address: _____ Town: _____ CT Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail _____

Health Consultant (Required)

Last name: _____ First: _____ Middle initial: _____

Resident Street Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

Work Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

Professional license held: Physician Physician Assistant AP Registered Nurse Registered Nurse

Professional License #: _____ License Expiration Date: _____

Early Childhood Education Consultant (Required)

Last name: _____ First: _____ Middle initial: _____

Resident Street Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

Work Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

DPH approval on file: Yes No

Name at time of approval if different: _____

PLEASE BE SURE TO COMPLETE THE REVERSE SIDE OF THIS FORM

Dental Consultant (Required)

Last name: _____ First : _____ Middle initial : _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional license held: Licensed Dentist Dental hygienist
Professional License #: _____ Expiration Date: _____

Social Service Consultant (Required)

Last name: _____ First: _____ Middle initial: _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional degrees held: BSW BA/ BS - Field of study: _____
 MSW MA/MS - Field of study: _____
Professional License # (if applicable): _____ Expiration Date: _____

Registered Dietitian Consultant (Required for programs that serve meals)

Last name : _____ First: _____ Middle initial: _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional license held: RD License/ID #: _____ Expiration Date: _____

CURRENT AGREEMENTS FOR ALL CONSULTANTS MUST BE SUBMITTED WITH THIS FORM

Head Teacher(s) (Required)

Please complete this section for each Department Approved Head Teacher at this program. If your program has more than (1) Head Teacher, please submit this information as an attachment.

Last name: _____ First: _____ Middle initial: _____
Resident Street Address _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Dept. of Public Health approval on file: Yes No Under 3 Years Preschool School Age
Name at time of approval if different: _____

**Please return this form to: Department of Public Health, Division of Community Based Regulation,
410 Capital Avenue MS#12 DAC, P.O. Box340308, Hartford, CT 06134-0308 or Fax (860) 509-7541**



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Community Based Regulation Section

ALL FAMILY DAY CARE HOMES, GROUP DAY CARE HOMES, AND CHILD DAY CARE CENTERS PROOF OF WORKERS' COMPENSATION INSURANCE

IF YOU HIRE EMPLOYEES TO WORK IN YOUR PROGRAM State Law (CGS Section 31-286a(b)) **requires** that no state department, board or agency may issue or renew a license, or permit to operate a business in this state unless the applicant first presents sufficient evidence of current compliance with the workers' compensation insurance coverage requirements of Section 31-284.

This means that if you hire employees to work in your family day care home, group day care home or child day care center on a part time or full time basis, you must submit to the Department of Public Health as part of your initial license application or relicensure application, sufficient evidence of compliance with this law.

For More Information Contact:

Your Insurance Agent or The Workers' Compensation Commission: 1-800-223-9675 or 1-860-493-1534

**THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR APPLICATION
FOR A CHILD DAY CARE LICENSE (EVEN IF YOU DO NOT EMPLOY STAFF)**

Program/Provider Name: _____ New Application
Address: _____ Relicensure Application
Town/State/Zip: _____ Telephone: _____ License #: _____

Do you hire employees in your program that requires you to obtain Workers' Compensation Insurance?
 Yes No

If "Yes", please check off which of the required certificates you have, as indicated below, and mail a copy of the certificate to the Department of Public Health, Day Care Licensing Program.

Sufficient evidence means: (Check off and enclose a copy)

- (1) a certificate of self-insurance issued by a workers' compensation commissioner pursuant to section 31-284; or
- (2) a certificate of compliance issued by the insurance commissioner pursuant to section 31-286; or
- (3) a certificate of insurance issued by any stock or mutual insurance company or mutual association authorized to write workers' compensation insurance in this state or its agent.

(Signature Operator/Provider)

(Date)

(Printed Name)

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Water Supply (Attachment# 13b)

Program Name: _____ License #: _____
Location Address: _____ Capacity: _____
City or Town: _____ (If **New** program, indicate “**New**” next
to license #.)

PLEASE BE SPECIFIC:

- Months of Operation (i.e. September-June): _____
- Days/Hours of Operation: Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____

Name of Property Owner: _____
Address: _____
City or Town: _____
Phone #: _____

Section 1

Are you or your landlord a Customer of a Water Company? Yes No

If Yes, complete Section 2 and provide the name of the Water Company: _____

If No, complete section 3

Section 2

Lead Water Test – Required for all programs every two years and when there are changes in water supply

Along with this form you **YOU MUST ATTACH** the following:

*A copy of the program’s most **recent water bill or other documentation**, for verification purposes, with the program location address on it;

* A copy of the program’s first draw **lead water test**;

*If you answered yes to Section 1 and completed Section 2, **DO NOT continue on to Sections 3 and 4***

Section 3

Facility has an on site well and serves less than 25 adults and children Yes No

If **YES**, you are required to submit both a first draw **lead water test** and **bacterial & chemical test**

If **NO**, complete **Section 4**

Lead Water Test – (Required for all programs every two years and when there are changes in water supply)

Bacterial & Chemical Test (Required every 2 years for all programs with on site wells serving less than 25 adults and children)

Along with this form, **YOU MUST ATTACH** the following:

*A copy of the program’s first draw **lead water test**

*A copy of the program’s **bacterial and chemical test**

CONTINUED ON BACK PAGE

Section 4 (Facility has on site well and serves 25 or more adults and children *at least 60 days of the year*)

Please Note: Your facility meets the classification of a Public Water Supply System and will be Referred to the Department of Public Health, Drinking Water Section.

Lead Water Test – (Required for all programs every two years and when there are changes in water supply)

Along with this form, **YOU MUST ATTACH** the following:

*A copy of the program's first draw **lead water test and bacterial and chemical test.**

