P.O. Box 4339, San Felipe NM 87001
Phone: (505) 867-3835
Fax: (505) 867-3383

Relative Child Care Provider Application Check List

(**For Office Use Only**)

Provider Name_____Phone #:_____

Address:_____

Email Address:_____

Completed & Attached:

_____Application
_____Copy of Driver's License/ID
_____Pre-service Training (Training certificate attached)
_____Home Inspection (copy of Self Certification attached)
_____National Sex Offender Registry Check – Date Checked:_____
_____NM ECECD Abuse & Neglect Check
_____TB Skin Test (results attached)
_____Physical Exam (results attached)
_____Fire Escape Plan
_____W-9 Tax Form
_____Proof of Vehicle Insurance (If authorized to provide transportation)
_____Proof of Registration (If authorized to provide transportation)
_____Emergency Preparedness Plan (must be completed within 3 months of start date)
_____SFCCP Keres Language Immersion Project Agreement
_____Work Schedule (if employed)

_____New _____Approved
_____Renewal _____Not Approved (See comments)

Comments:_____

_____

_____ _____

Child Care Coordinator Signature Start Date

Revised: 06/27/23

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Provider Information:

Name:_____Ph. #:_____

Physical Address:_____

Mailing Address:_____

Email Address **(Required)**:_____

SS#:_____DOB:_____

Relative Provider Definition: One who is related to the child by blood or marriage as a Great Grandparent, Grandparent, Aunt, Uncle, Sibling or Cousin?

Based on the definition, what is your relation to the child or children you will be serving?:

_____

Are you currently participating in a Food Program? _____Yes _____No

If yes, Food Program Name?_____

Contact Name:_____Phone #:_____

Are you currently Employed? _____Yes _____No

If yes, Place of employment?_____

Supervisor Name:_____Phone #:_____

(Please attach a copy of your work schedule)

What is your Primary Language? ___Keres ___English ___Both

It is the Pueblo of San Felipe Child Care Program Policy that all perspective Child Care Providers speak the Keres language so that we can all work together to increase Keres fluency for all children receiving services through our program. If you are a fluent Keres speaker, we would encourage you to participate in our Keres Language Immersion Project. The child care staff will provide you with the KLIP Agreement form during Orientation and share more information regarding the KLIP.

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Transportation:

Will you be providing transportation as part of your services for the children in your care (i.e. appointments, school, field trips, etc.)? _____Yes ____No

If yes, a Permission to Provide Transportation Form must be completed by the parent allowing you to provide transportation. You must provide a copy of your Driver's License, Proof of Insurance and Vehicle Registration along with this application. You will need to attend a Car Seat Installation Training if children in care are required to be in a car seat/Child Passenger Safety Training if children in care are no longer required to be in a car seat or both trainings if children in care are a mixed age group. You must provide proof of attending training/trainings within 3 months of service start date. Transportation of children cannot begin until the above is complete.

Household Composition:

List all **adults 18+,** living in your home. (Include First, Middle and Last Name):

Name:_____DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

If there are additional adults, list them on the back of this page.

Certification:

I, _____ certify that the information provided in this application is true and correct to the best of my knowledge. I understand that if what I have reported is misleading or incorrect information, my application will be denied. (a Civil Complaint may be filed with the San Felipe Tribal Courts if any fees were paid by POSFCCP on behalf of this application).

_____ _____

Provider Signature Date

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Provider Agreement;

I,_____ hereby enter into this agreement with the Pueblo of San Felipe Child Care Program and will abide by the following terms. Failure to maintain the terms as outlined below will result in my termination from the program.

1. I agree I am eighteen (18) or older and hereby file this application to operate a Family Child Care Home for a period not to exceed one (1) calendar year.
2. I agree that I reside at the address listed on this application and will provide child care services at this location only.
3. I agree to inform the POSFCCP staff of any changes that may occur during the time this agreement is in effect.
4. I agree to allow the POSFCCP staff to enter my home during Home Inspection and Monitoring visits. Announced and Unannounced visits wil be done periodically throughout my participation with the program.
5. I agree to the process pertaining to Unannounced visits as outlined in the POSFCCP Policies & Procedures Handbook.
6. I agree to comply with the Health and Safety Standards as outlined in the Self Certification Child Care Home Registration, while rendering child care services to children in my home.
7. I agree to the process pertaining to Non-compliance of Health and Safety Standards, as outlined in the POSFCCP Policies & Procedures Handbook.
8. I agree to provide child care services in an Alcohol and Drug-free environment.
9. I agree to participate in training's provided. (12 hours required before the end of my one-year provider agreement).

I will provide a safe, loving and nurturing home environment filled with play, fun and learning for all children in my care. I fully understand that I am providing services for children because the parent(s)/guardian(s) are working, attending school or in a job training program. My services wll be based on the Child Care Placement Agreement Schedule, completed by parent(s)/guardian(s). Any additional services will be at the expense of the parent(s)/guardian(s).

_____ _____

Provider Signature Date

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CHILD CARE PROVIDER PHYSICAL EXAM REPORT

The Child Care Provider Physical Exam Report is to be completed by a health care provider. The completed form must be submitted to the POSFCCP as part of eligibility or continued eligibility.

A. TO BE COMPLETED BY CHILD CARE PROVIDER:

Name: _____DOB: _____

Address: _____

PLEASE READ: Child Care Providers are expected to maintain physical and mental health to perform their job. The Physical Exam Report is used to assess the individual's ability to perform the following child care activities:

- Be responsible for children's physical and social development during the day and/or nighttime hours
- Need to lift children, bend and stand for long periods of time
- Ability to make sound judgements.

B. THIS SECTION MUST BE COMPLETED BY A PHYSICIAN

	Yes	No	Remarks
1. Did you conduct a physical examination? This physical examination should include a functional assessment of vision and hearing and a system review looking for conditions that might affect performance or predispose this individual to occupational injury relating to the type of activities required as listed above. Other conditions include frequent hand washing, the stress of caring for groups of children, ability to actively supervise children, and exposure to common childhood infections. Please take note that substance abuse should be considered in determining suitability to provide child care.			
2. Did this individual have any communicable diseases? If yes, attach separate sheet(s) to describe the conditions and the risk it might pose to others exposed to this individual.			
3. Does this individual have any behavioral and/or mental health conditions that might endanger the health of children or might prevent them from providing adequate care for children?			

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If you answered "Yes" to question #3 please list any information regarding this individual's medical condition or other information gathered during your examination that might threaten the health of children or prohibit the individual from providing safe and adequate care to children. Attach separate sheet if needed.

	Yes	No	Remarks
4. Based on your findings above and other information gathered during your examination, is this individual suitable to provide child care services?			
5. Is the individual up-to-date on age appropriate immunizations including COVID Vaccines/Boosters?			

TUBERCULOSIS SKIN TEST AND/OR X-RAY

Skin Test Date :	**Positive**	**Negative**
If Skin Test is Positive: Report Chest X-Ray (please attach an official radiology report)		

Additional Remarks:

Health Care Provider Printed Name:

Signature of Health Care Provider: Date:

Address of Health Care Facility: Phone Number:

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