

NAFCC Accreditation Application

Note: To apply for accreditation, providers must be enrolled in self-study or be re-accrediting providers that have completed their first & second annual updates.



By submitting this application you are demonstrating your commitment to complete the accreditation process. You believe that you meet all the eligibility criteria, have completed the application requirements, are meeting the Quality Standards, and have planned when you will be able to have an observation visit.

Make sure the application is filled out completely and all application requirements are included. Submission of an incomplete packet will delay the accreditation process and additional fees will be incurred.



E l i g i b i l i t y C r i t e r i a

- Be at least 21 years of age
- Have a high school diploma or GED
- Provide care to children for a minimum of 15 hours per week
- Provide care to a minimum of three children in a home environment. At least one child must not reside in the provider's home
- Be the primary caregiver, spending at least 80% of the operating hours actively involved with the children. Co-providers must spend at least 60% of the time actively involved with the children
- Have at least 12 months experience as a family child care provider.
- Meet the highest level of regulation to operate a family child care program by the authorized regulatory body
- Be in compliance with all regulations of the authorized regulatory body
- Have a favorable state and federal criminal history
- Be in good health in order to provide a nurturing and stable environment for children
- Maintain a current First Aid and Pediatric CPR certification
- Adhere to the NAEYC Code of Ethical Conduct

A p p l i c a t i o n R e q u i r e m e n t s

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Application <input type="checkbox"/> Application Fee <input type="checkbox"/> Current NAFCC Membership (if paying discounted fees) <ul style="list-style-type: none"> <input type="checkbox"/> Provider <input type="checkbox"/> Co-Provider <input type="checkbox"/> Current License <input type="checkbox"/> Health Assessment Form (within 2 years) <ul style="list-style-type: none"> <input type="checkbox"/> Provider <input type="checkbox"/> Co-Provider <input type="checkbox"/> Assistants <input type="checkbox"/> TB Screening Form (within 2 years) <ul style="list-style-type: none"> <input type="checkbox"/> Provider <input type="checkbox"/> Co-Provider <input type="checkbox"/> Assistants | <ul style="list-style-type: none"> <input type="checkbox"/> Current First Aid and Pediatric CPR <ul style="list-style-type: none"> <input type="checkbox"/> Provider <input type="checkbox"/> Co-Provider <input type="checkbox"/> Assistant <input type="checkbox"/> State and Federal Background Checks (within 3 years) <ul style="list-style-type: none"> <input type="checkbox"/> Provider <input type="checkbox"/> Co-Provider <input type="checkbox"/> Assistant <input type="checkbox"/> Adults 18+ Living in FCC Home <input type="checkbox"/> Training Log and Verification (within 3 years) <ul style="list-style-type: none"> <input type="checkbox"/> Provider <input type="checkbox"/> Co-Provider |
|---|---|

NAFCC Accreditation Application

C a n d i d a t e I n f o r m a t i o n		
First Name	MI	Last Name
Business Name / Name on License		
Address on License, Registration or Certificate		Phone
		Fax
Mailing Address		Email
City	State	Zip
County		Country
Military Base/Installation		I would prefer materials in... <input type="checkbox"/> English <input type="checkbox"/> Spanish I need a bilingual observer <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> I am going through NAFCC Accreditation with an Agency/Project/Mentor.		
Agency/Project Name/Mentor _____		Please complete this section if you are receiving technical assistance or financial assistance/re-imbursement.
Contact Person _____ Address _____		
Phone _____ Email _____		
Are you currently an individual member of NAFCC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Membership fee included (\$45)	Are you over 21 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	I am applying for... <input type="checkbox"/> 1st Accreditation <input type="checkbox"/> Re-accreditation Most current accreditation exp. / / I have been accredited _____ times?
Education (check all that apply): <input type="checkbox"/> Less than High School <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Some College		
<input type="checkbox"/> Associate Degree _____ Year Obtained _____ <input type="checkbox"/> Bachelors Degree _____ Year Obtained _____ <input type="checkbox"/> Masters Degree _____ Year Obtained _____ <input type="checkbox"/> Doctorate Degree _____ Year Obtained _____		<input type="checkbox"/> I have a Current Family Child Care CDA (Child Development Associate)
How long have you taken care of children in a home environment for pay? <input type="checkbox"/> Less than 12 mos. How many mos.? _____ <input type="checkbox"/> 12 mos-2 yrs. <input type="checkbox"/> 3-5 yrs. <input type="checkbox"/> 5-10 yrs. <input type="checkbox"/> 11-20 years <input type="checkbox"/> 20+ yrs.		Is your family child care program regulated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Licensed <input type="checkbox"/> Registered <input type="checkbox"/> Certified <input type="checkbox"/> Not available
How many children are enrolled in your program? _____ How many of those children live outside your home? _____		Have you had any formal complaints or areas of non-compliance against your family child care home in the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include an explanation giving complete details of the complaint(s) or areas of non-compliance, the outcome, when, what, how resolved, and all correspondence from the regulatory agency.
Are you on site and actively involved with children at least 80% of the hours your program is open, or at least 60% if you have a co-provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		

NAFCC Accreditation Licensing Consent



NAFCC must verify that the candidate is in compliance with all regulations of the authorized regulatory body. Most state or county licensing departments require written consent to request a provider record search. Complete the following consent and licensing agency contact information. NAFCC will obtain the required information.

Please provide complete and accurate information to help prevent delays in your accreditation process.

I, _____ give consent for my licensing agency to provide written information to the National Association for Family Child Care (NAFCC) on any past allegations, unresolved complaints, and/or issues of non-compliance regarding my child care program within the past 3 years.

This consent shall remain valid and shall extend throughout my participation in the Accreditation Program sponsored by NAFCC.

Licensing Agency

Agency Contact Person	Email
-----------------------	-------

Phone	Fax
-------	-----

Agency Address

City	State	Zip Code
------	-------	----------

License/Registration #

Provider Signature	Date
--------------------	------

NAFCC
 700 12th Street NW
 Suite 700
 Washington, DC 20005
 Phone: 202-796-5700
 Fax: 801-886-2325
www.nafcc.org

Are there any other adults over age 18 living in the FCC home? Yes No

If yes, list their names below and submit State and Federal Background Checks (within 3 years) for all adults over age 18 living in the FCC home.

Name	Name
Name	Name
Name	Name
Name	Name

Do you have assistants? Yes No

If yes:

List their names below and complete assistant/co-provider schedule on page 6

Assistants are at least 16 years old and work under the supervision of a provider. They are not left in charge unless they meet all of the qualifications of substitutes (Quality Standard *5.34).

Submit the following for all assistants:

- Current First Aid and Pediatric CPR
- Health Screening (within 2 years)
- TB Screening for all assistants (within 2 years)
- State and Federal Background Checks (within 3 years)

Name	Name
Name	Name
Name	Name
Name	Name

Do you have substitutes? Yes No

If yes, submit State and Federal Background Checks (within 3 years) and list their names below

Name	Name
Name	Name
Name	Name
Name	Name

Candidate - First Name _____ Last Name _____

Do you have a co-provider? Yes No

If yes, you and your co-provider must :

- Complete assistant/co-provider schedule on page 6
- Complete certification on page 12

Your co-provider must:

- Complete co-provider information below
- Submit the co-provider fee

Co-providers are two providers who share equally in the decision making and responsibility. Each co-provider must be on-site and actively involved with the children at least 60% of the time care is offered. Co-providers must submit all application requirements.

C o - P r o v i d e r I n f o r m a t i o n		
First Name	MI	Last Name
Are you currently an individual member of NAFCC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Membership fee included (\$35)		Are you over 21 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No
Education (check all that apply): <input type="checkbox"/> Less than High School <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Associate Degree _____ <input type="checkbox"/> Bachelors Degree _____ <input type="checkbox"/> Masters Degree _____ <input type="checkbox"/> Doctorate Degree _____ <input type="checkbox"/> Current Family Child Care CDA (Child Development Associate)		
How long have you taken care of children in a home environment for pay? <input type="checkbox"/> Less than 18 mos. How many mos.? _____ <input type="checkbox"/> 18 mos-2 yrs. <input type="checkbox"/> 3-5 yrs. <input type="checkbox"/> 5-10 yrs. <input type="checkbox"/> 11-20 years <input type="checkbox"/> 20+ yrs.		
Are you on site and actively involved with children at least 60% of the hours your program is open? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Provider/Assistant/Co-Provider Schedule

List your name, the names of all assistants and co-providers if you have them and daily scheduled hours.

Name	MON	TUE	WED	THU	FRI	SAT	SUN
Ex. Jan Smith	7 am/pm - 1 am/pm	___ am/pm - ___ am/pm	7 am/pm - 1 am/pm	___ am/pm - ___ am/pm	1 am/pm - 5 am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm

P r o g r a m I n f o r m a t i o n

My program operates 12 months/year My Program operates less than 12 months/year
 Please indicate the most current program beginning and ending date.
 Program Beg. Date / / Program End Date / /

Hours of Operation	MON	TUE	WED	THU	FRI	SAT	SUN
Opening	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm
Closing	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm
Opening	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm
Closing	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm

Regularly Scheduled Outings: Please list any regularly scheduled weekly outings

Example	MON	TUE	WED	THU	FRI	SAT	SUN
Library							
___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm	___ am/pm
- ___ am/pm	- ___ am/pm	- ___ am/pm	- ___ am/pm	- ___ am/pm	- ___ am/pm	- ___ am/pm	- ___ am/pm

Are others regularly in the family child care home, i.e. your family, parents, volunteers, program specialists, children that are not enrolled in the program?

Yes No If yes, please list who, when, and what their role is.

	MON	TUE	WED	THU	FRI	SAT	SUN
Name (Ex)	Suzie Singer						
Role	Music Spec.						
Schedule	1 am/pm 2 am/pm	___ am/pm - ___ am/pm	10 am/pm 11 am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							
Schedule	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm	___ am/pm - ___ am/pm
Name							
Role							

C h i l d E n r o l l m e n t I n f o r m a t i o n															
Number of children enrolled _____				Number of families enrolled _____											
Indicate the number of enrolled children in each age group. What is your capacity?															
Babies (Birth to 1st Birthday)		Toddlers (Age 1 to 3rd Birthday)		Pre-School (3-5 yrs.)		School-Aged (6-12 yrs.)									
Enrollment: List each child enrolled in your program by their first name, birth date, their weekly schedule and original date of enrollment. Indicate the days of the week each child attends and total how many children are in care each day at the bottom of the page. Use multiple lines for children with split schedules, e.g., before and after school care. If the child is a sibling to another in the program, please indicate the sibling's name. Siblings must also be listed on their own line with their birth date and schedule. Also, indicate if any of the children are the provider's own children.															
Enrolled Child's 1st Name	Birth Date	Weekly Schedule							Orig. Enroll. Date	Sibling's 1st Name	Prov. Child Yes/No				
		Days			Hours										
		M	T	W	T	F	S	S							
(Ex.) Adrianna	5/13/09		√						7:30am-5:00pm	11/2009	n/a	no			
(Ex.) Joel	10/6/09				√	√	√	√	10:00am-3:00pm	2/2011	n/a	no			
Total # of children per day for <u>this page only.</u>		M-		T-		W-		Th-		F-		S-		Su-	

Child's 1st Name	Birth Date	Weekly Schedule							Orig. Enroll. Date	Sibling's 1st Name	Prov. Child Yes/No
		Hours									
		Days									
M	T	W	T	F	S	S					

Total # of children per day for <u>this page only</u> .	M-	T-	W-	Th-	F-	S-	Su-
Total # of children per day. Add BOTH pages.	M-	T-	W-	Th-	F-	S-	Su-

Information for Observer

Program Setting (check all that apply)

Suburban Rural Urban Military Base Gated Community

If you live on a military base or in a gated community indicate below (or attach) how the observer can arrange to gain access without contacting you prior to the day of the observation. Please include all necessary contact information.

Parking Considerations: Specify any parking instructions the observer might need the day of the visit, i.e. “park in parking lot across the street,” “park in driveway to the left of site,” “you will have to park at a meter and will need change.”

Directions: Indicate the nearest major landmark, highway off-ramp, or major intersection. If possible, please attach computer generated instructions or detailed map.

Provider Certification

- I certify that all information provided is accurate and complete. (This box must be checked.)
- I certify that I meet all eligibility requirements. (This box must be checked.)
- I certify I have read the NAEYC Code of Ethical Conduct and agree to adhere to it's guidelines. (This box must be checked.)
- I understand I must submit the complete application, all required documentation, and all applicable fees. Failure to submit a complete application could result in my application being returned to me and additional fees may be incurred. (This box must be checked.)
- I understand that the application fees are non-refundable. (This box must be checked.)
- I understand that the National Association for Family Child Care has the right to revoke accreditation if non-compliance of the Quality Standards is determined and/or if eligibility is not met. I also understand modifying or amending the documentation in anyway may result in accreditation becoming null and void. (This box must be checked.)
- I give permission to the National Association for Family Child Care to release my name, address, and telephone number to persons seeking accredited providers.

Provider Signature

Date

Co-Provider Certification

- I certify that all information provided is accurate and complete. (This box must be checked.)
- I certify that I meet all eligibility requirements. (This box must be checked.)
- I certify I have read the NAEYC Code of Ethical Conduct and agree to adhere to it's guidelines. (This box must be checked.)
- I understand I must submit the complete application, all required documentation, and all applicable fees. Failure to submit a complete application could result in my application being returned to me and additional fees may be incurred. (This box must be checked.)
- I understand that the application fees are non-refundable. (This box must be checked.)
- I understand that the National Association for Family Child Care has the right to revoke accreditation if non-compliance of the Quality Standards is determined and/or if eligibility is not met. I also understand modifying or amending the documentation in anyway may result in accreditation becoming null and void. (This box must be checked.)
- I give permission to the National Association for Family Child Care to release my name, address, and telephone number to persons seeking accredited providers.

Co-provider Signature

Date

Research Information

The following questions are for research information only and will not be considered in determining provider eligibility or accreditation status. Completion of this section is greatly appreciated.

Is assistance available to Family Child Care Providers to help pay accreditation fees in your area? Yes No

Did you receive assistance to help pay any of your accreditation fees? Yes No

How much assistance did you receive to help pay your accreditation fees? 25% or less 50% 75% 100%

Is accreditation support (other than assistance with accreditation fees) available to assist family child care providers in your area as they pursue accreditation? Accreditation support may include accreditation study groups, coaches or mentors, training or funding for training, or funding for quality improvements (facility, equipment, etc.).

Yes No

Did you receive any accreditation support (other than assistance with accreditation fees)? Yes No

Provide contact information for the agencies that provide accreditation support in your area.

Agency:	Agency:
Contact:	Contact:
Address:	Address:
City: State: Zip:	City: State: Zip:
Email:	Email:
Phone:	Phone:

Where do you provide family child care?

In my residence In someone else's residence In a home that no one resides in

Other (specify) _____

What languages are you fluent in? English Spanish Other (specify) _____

How many children in your program speak what languages?

_____ English _____ Spanish _____ Other (specify) _____

How many children in your program are...

_____ American Indian or Alaskan Native _____ Asian or Pacific Islander _____ Black, not of Hispanic origin

_____ Hispanic _____ White, not of Hispanic origin _____ Other (specify) _____

How many children in your program are formally diagnosed with special needs? _____

What special populations do you serve? None Military Migrant workers

Teen parents Single parents Homeless families Other (specify) _____

How many children receive financial assistance to attend your program?

_____ Scholarships _____ Sliding fee scales _____ Public subsidies

How many assistants in your program have credit bearing college level course work? _____ Less than 6 units

_____ 6-9 units _____ 10-24 units _____ Associate Degree _____ Bachelor's Degree _____ Master's Degree or higher

How many assistants do you have in each age group?

_____ under 18 _____ 18-21 _____ 22-30 _____ 31-40 _____ 41-50 _____ 51+

Candidate - First Name _____ Last Name _____

P a y m e n t I n f o r m a t i o n

Note: To apply for accreditation providers must be enrolled in self-study or be re-accrediting providers that have completed their first & second annual updates.

Please send the completed NAFCC Accreditation Application with payment to:

Contact NAFCC

NAFCC
700 12th Street NW
Suite 700
Washington, DC 20005

Phone: 202-796-5700
Fax: 801-886-2325
accreditation@nafcc.org
www.nafcc.org

Fees are non-refundable and non-transferable.

Member #

- \$45 **Membership Renewal Fee**
 \$525 **Application Fee**
 \$100 **Co-Provider Fee**

Total amount \$ _____

Non-Member

- \$735 **Application Fee**
 \$150 **Co-Provider Fee**

Total amount \$ _____

A personal check is enclosed. Check # _____ Make check payable to: NAFCC Accreditation

My accreditation fees are being paid by Agency/Project (specify) _____

Army Navy Air Force Other (specify) _____

Card #

Expiration Date _____

Name on Card (please print)

Billing Address

City

State

Zip

Signature _____

NAFCC is going green! Did you provide us your email? Receive accreditation updates, information regarding your process, and special promotions via email.

***Make sure we have a valid email address so you won't miss out.
Add us to your safe sender list.***

Email

Phone Number