FFN Application Instructions

As a new provider, your license beginning date starts when your FBI background checks and required training is completed. 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&R) Child Care Resources and Referral facility in your district.

https://dphhs.mt.gov/ecfsd/childcare/childcareresourceandreferral

If you are providing care in the parent's home, the parent's case worker must approve.

TRAINING REQUIREMENTS

- All on-line training courses are available at www.Childcaretraining.org. For assistance call 406-728-6446. An access code is needed to enroll in the course(s).
- the ACCESS CODE is: **HCeibcTm**

HEALTH AND SAFETY OVERVIEW

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

FFN FUNDAMENTALS

- FFN Fundamentals course is required for all 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.

ANNUAL TRAINING

- A total of 8 hours of training approved by ECP (must be completed by renewal date)

If you have questions or need additional forms or information, please visit our website located at: https://dphhs.mt.gov/ecfsd/childcare/childcarelicensing/lcpapplication.

email: FFNPPROGRAM@MT.GOV
phone: (406) 444-2012
Fax: (406) 444-2750

Child Care Licensing
PO BOX 4210
Helena MT 59620-4210

Family, Friend & Neighbor
Renewal Provider Application

1. I am Renewing my FFN Program child care registration.

I will be providing child care in my home, ☐ or the Parent's home (approval required) ☐

In the past, have you been a Registered or Certified Child Care Provider Yes ☐ No ☐

If yes, What type: _____ Where: _____ Date: _____

Have you been approved, in any capacity, to provide care in a child care facility? Yes ☐ No ☐

If yes, Facility Name/Date: _____

2. Provider Information

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

Legal Name:

Last, First, Middle _____

City

Residential Address: _____

Zip Code

Mailing Address: Same as above ☐ _____

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

Cell Number: _____ Other Ph. No.: _____

Email Address: _____

3. Household Members

A background check is needed for all household members, 18 years of age or older, must complete the following forms:

- **Release of Information:** The Release of Information Criminal/Protective Service Background Check form must be signed by the applicant and any adult in the household 18 years or older. This form is used to obtain information from the Montana Department of Justice, Montana Child Protective Services, Adult Protective Services, and if applicable, the Tribal Law Enforcement and Child Protective Services.
- **FBI - Fingerprint Disclosure Statement:** This form is needed regardless of where the individual listed has lived.
- **Statement of Health:** Applicants must meet certain personal health requirements. As the agency responsible for child care certification, the Department of Public Health and Human Services (DPHHS) must ensure that the health of all providers and family members is adequate to meet the demands of the care being provided. Additional forms are available to download at: https://dphhs.mt.gov/ecfsd/childcare/childcarelicensing/lcpapplication

Household Member(s) (HHM) Last, First, Middle Name	Date of birth	Age	Relationship to the Child Care Provider
Provider:			
HHM:			
HHM:			
HHM:			
HHM:			
HHM:			

4. Child Abuse and Neglect

- At any time, have you had a child removed from your home? No ☐ Yes ☐ If yes, where and when date(s)?

_____

- At any time, 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 occur?

_____

_____

Training Requirement(s): All on-line training courses are available at **www.Childcaretraining.org**
For access and training assistance, phone: 800.728.6446

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 course is required for **all providers,** and must be completed before the initial license is approved.

FFN FUNDAMENTALS

- The FFN Fundamentals training course is required for **all providers**. This class must be completed within 60 days of registration.

***CPR/FIRST AID CERTIFICATION* (hands-on)**

- Infant, Child, and Adult CPR/First Aid training is required for non-relative care providers.
- Call your local Child Care Resource Center, local fire dept. hospital, etc. for class availability.

Family, Friends & Neighbor
Child Care
Family Association Information

1. Provider:

Provider Name: _____

Are you included in the parent's TANF grant? **Yes** ☐ **No** ☐

2. Family Information

This is the family, who the Friend & Neighbor Child Care Provider will be providing child care; the family that is receiving the Best Beginning Scholarship.			
Head of Household Parent (s)Name:	Case #:		
Address:	City County:		
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 the Child Care provider.

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 program 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 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. Following are 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 checking 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

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: _____ Zip Code: _____

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
Child Care
Statement of Health

Name: _____

Please check one of the boxes below:

- ☐ I am applying to be the child care 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 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