SIOUX FALLS HEALTH DEPARTMENT

Family Day Care Home Registration Form–Provider

Receipt Number ___________________
Receipt Date ______________________

SECTION A

Applicant/Billing Information

Name of Applicant ________________________________ Phone ________________________

Address of Child Care Home ___________________________ Fax _______________________

City ______________________ State ________________ Zip ____________________

Applicant's Date of Birth ______________________ Applicant's Social Security No. _ _ _ -_ _ -_ _ _ _

SECTION B

Please list names of **ALL** individuals 15 years and older who reside or who will be present on the premises on a regular basis. Please note whether or not the individual is a provider who works with children.

Name	Address	Date of Birth	Helper	Provider	N/A
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

How many children including applicant's own children under the age of 7 will be in attendance at the child care home? _________

SECTION C

You may return this form with the following information; or if you would like to use the free educational classes and TB test provided by the City of Sioux Falls, then return this application with the $15 fee. This application with the appropriate fee <u>must</u> be on file at the Sioux Falls Health Department if you intend on using these free services.

Please check if you have provided the following *additional* information for ***all providers and individuals*** in the Family Day Care before the final permit can be issued:

☐ Documentation of a negative test for active TB *or* ☐ on record if test conducted at Falls Community Health.

☐ Documentation that the providers have acquired 6 continuing education credits in the previous year. (Cannot repeat classes within 3 years.)

☐ Documentation that provider is current on certification for infant/child CPR and First Aid.

☐ Documentation that provider has not been convicted of a felony in the past five years.

☐ Documentation that no one who is regularly in the home is on the central registry for abuse and neglect.

☐ Provide master list of all children present at the day care with contact information in case of an emergency.

SECTION D (This section must be filled out for the application to be processed.)

Have you or any person who frequents the home, as a provider or otherwise, ever been arrested or convicted of an offense for which they would need to register as a sex offender in South Dakota or any other jurisdiction or any lesser or similar related charge? ☐ Yes ☐ No

If yes, explain ______________________________

Have you or any person who frequents the home ever been arrested, convicted, or put on notice for child abuse and/or neglect? ☐ Yes ☐ No

If yes, explain ______________________________

Have you or any person who frequents the home been arrested and/or convicted of a felony in the past five years? ☐ Yes ☐ No

If yes, explain ______________________________

Have you or any person who frequents the home been incarcerated in a federal, state, county, or local correctional facility in the last 10 years? ☐ Yes ☐ No

If yes, explain ______________________________

Have you ever been a licensed or registered day care provider? ☐ Yes ☐ No

If yes, where and when ______________________________

Have you ever been or are you currently a State of South Dakota Licensed/Registered Day Care Provider?
☐ Yes ☐ No

If yes, when ______________________________

Have you ever had a day care license or registration revoked or suspended? ☐ Yes ☐ No

If yes, explain ______________________________

SECTION E

The Sioux Falls Health Department will issue or renew a registration permit only after payment of the proper fee, including any late fees, ascertainment that facts set forth in the application are true and complete, and satisfactory evidence of the applicant's ability to comply with the provisions of Chapter 19 of the Revised Ordinances of Sioux Falls. The registration fee is $15.00. This is a nonrefundable fee for the application process, which will not be returned. The fee is not a guarantee of registration, since all requirements for registration according to City ordinance must be met prior to certificate issuance. **Registration fee must accompany application for processing. If all required information for processing is not included, the application and its contents will be filed for 90 days or until all requirements are met and all required documentation provided, whichever is shorter. By signing you are verifying the accuracy of this information to the best of your knowledge.**

Make checks payable to: **City of Sioux Falls**

Submit to: **Sioux Falls Health Department**
521 North Main Avenue, Suite 101
Sioux Falls, SD 57104-6419
605-367-8760

Signature of Applicant: ______________________________ Date: ____________________

OFFICE USE ONLY:

Approved by: ________________________ Sex Registered Check: _______ Date: ________________

Date	Time	Notes	Initials