

STATE OF MONTANA  
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES  
DIVISION OF QUALITY ASSURANCE

**CHANGE OF STATUS APPLICATION  
FOR REGISTRATION / LICENSE OF  
INFANT, FAMILY, GROUP, and CENTER DAY CARE FACILITY**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Facility: \_\_\_\_\_ PV# \_\_\_\_\_

Physical Address \_\_\_\_\_

Street City State Zip

Mailing Address \_\_\_\_\_

Street City State Zip

Directions to day care site (From the nearest major street or highway) \_\_\_\_\_

*I would like to change my registration status*      **From:** [ ] Family [ ] Group [ ] Center  
**To:** [ ] Family\* [ ] Group\*\*

\*(Family homes allow a maximum of 6 children)      \*\*(Group homes allow a maximum of 12 children)

\*\*\* (Centers are licensed to take over 12 children, maximum number of children allowed varies)

**Date that the change is effective:** \_\_\_\_\_

**Number of own children**, under the age of 6, that will be cared for at the facility: \_\_\_\_\_

**Please mark the youngest and oldest age of children, you wish to provide care to:**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>

**Hours of operation** (days and hours): \_\_\_\_\_

**OVERLAP CARE:**

Are you, or do you wish to be, certified for Overlap Care? [ ] Yes [ ] No [ ] Already Approved  
If Yes or already approved, Please Answer next question

Are your Overlap Times changing, or is this a new request? [ ] Yes [ ] No **If Yes, Please complete Overlap Form.**

**DAY CARE LOCATION:**

Is the day care located in your residence? [ ] Yes [ ] No

**If Yes, Please complete both the Household Member table and the Caregivers table**

**If No, you only need to complete the Caregivers table.**

**HOUSEHOLD MEMBERS**

\*In the space provided below please include the name and birth date, of all persons presently living in the home, where day care will be provided. **(Please include yourself, if you reside there)**

Name	Date Of Birth	Relationship
1		
2		
3		
4		
5		

**CAREGIVERS**

Please list the names, address, and phone number of all persons responsible for the direct care and supervision of children in your facility and indicate whether they are full or part time.

PS# (From PS# Card)	NAME	POSITION	WORKS 160 Hrs/Yr	
			More Than	Less Than
1				
2				
3				
4				

All **NEW** caregivers must submit the following:

- Complete Employee Cover Sheet;
- Complete Release of Information;
- Complete Statement of Health;
- Proof of MMR and Tetanus Diphtheria (within the last 10 years); and
- Proof of current Adult, Infant, and Child CPR and First Aid Certification.

**COMMENTS:**

In Accordance with the Montana Child Care Act, (52-2-702-714), Montana Code Annotated, I hereby request the re-issuance of a Infant, Family, Group, or Day Care Center Certificate of Registration / License on the basis of my affirmation of the following statements:

Please  
Initial

- \_\_\_\_\_ a. I have received and have read a copy of the State Regulations for Family Group Day Care Homes, Day Care Centers and Infant Care.
- \_\_\_\_\_ b. I certify, to the best of my knowledge and belief that, I will be in compliance with the State Regulations for Family/Group Day Care Homes, Day Care Centers, and Infant Care, while children are in care.
- \_\_\_\_\_ c. I understand that I cannot care for more children at any one time than are indicated by the Registration/License Certificate. This number includes my own children under the age of 6 years.
- \_\_\_\_\_ d. I understand that any complaints about my registered/licensed day care facility may be investigated by a representative of the Department, without prior notification.
- \_\_\_\_\_ e. I understand that my registered/licensed day care facility may be visited, and I will allow worker entry.
- \_\_\_\_\_ f. If I move to another address or stop providing care to children I must notify the Department of Public Health and Human Services, Child Care Licensing Program.
- \_\_\_\_\_ g. I understand that the name and address of my registered day care home will appear on a list which is maintained by the Department of Public Health and Human Services
- \_\_\_\_\_ h. I will keep the necessary Insurance in force covering the total number of children I am caring for. I certify that I have adequate Public Liability and Fire Insurance for the purpose of conducting child day care. **Your insurance agent must complete the “Insurance Verification Form”.** If you are renting we need a copy of your landlords Fire Insurance and written approval from your landlord that he does not mind you providing day care services.
- \_\_\_\_\_ i. I will provide the department with the names, addresses, phone numbers, and parents’ names, of each child in my care whenever requested to do so by the department.

*To the best of my knowledge and belief, all information I have given to the Department of Public Health and Human Services and/or its authorized agents on this form is true and correct. I will supply true and correct information requested during all subsequent contacts.*

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**TO BE COMPLETED BY A NOTARY PUBLIC:**

Taken, Sworn, and subscribed before me, this \_\_\_\_\_ day of \_\_\_\_\_ A.D. \_\_\_\_\_

\_\_\_\_\_  
(Notary Public for the State of Montana)

Residing at \_\_\_\_\_

My Commission Expires \_\_\_\_\_