

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

**RENEWAL APPLICATION  
FOR LICENSED CHILD CARE CENTERS**

*\*If the applicant answers to a source other than a sole proprietor (executive board, board of directors, other owner, etc.), the individual that is responsible for the day care facility must complete this form.*

**Child Care Center Facility Information:**

**Facility Name:** \_\_\_\_\_ **Provider Number** \_\_\_\_\_

**Facility Phone #** \_\_\_\_\_ **E-Mail** \_\_\_\_\_

**Facility Address** \_\_\_\_\_  
Street City State Zip

**Mailing Address** \_\_\_\_\_  
Street / PO City State Zip

\*If you are renting, please make sure it is ok with your landlord to provide day care services on the rental property.

**Director Information:**

**Director Name:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street City State Zip

Is the Owner/Board President present in the facility on a regular or frequent basis?  Yes  No

**Number of children for whom care will be provided:** \_\_\_\_\_ **Number of Infants:** \_\_\_\_\_

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

0	1	2	3	4	5	6	7	8	9	10	11	12

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

**Fire Marshal Certification**  Yes  No \_\_\_\_\_ by \_\_\_\_\_  
Date of Inspections Name of Fire Marshall

**Health Department Certification**  Yes  No \_\_\_\_\_ by \_\_\_\_\_  
Date of Inspection Name of Inspector

**I hereby agree to an on-site investigation of the facility, including the program and the qualifications of the staff members by a representative of the Department of Public Health and Human Services to determine whether the licensing requirements of the Department have been meet.**

**CHILD CARE STAFF - Please complete Staff Master List and Employee Cover Sheets.**

**SWORN STATEMENT**

In Accordance with Section 52-2-701 through 52-2-741, Montana Code Annotated, I hereby request the issuance of a Day Care Center 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 Day Care Centers that include the supplemental regulations for Infant Care.
- \_\_\_\_\_ b. I certify that I intend to remain in compliance with the licensing requirements for day care centers.
- \_\_\_\_\_ c. I understand that I may not care for more children at any one time than are indicated by the day care license.
- \_\_\_\_\_ d. I understand that any complaints about my licensed day care center may be investigated by a representative of the Department, without prior notification.
- \_\_\_\_\_ e. I understand that my day care center may be visited at any time by the parent(s) or a child in care or by a representative of the Department, and I will allow 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 day care center will appear on a list that is maintained by the Department of Public Health and Human Services and made available to the public upon request.
- \_\_\_\_\_ 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. **Please provide us with the name of your insurance company, the contact person, policy number, effective dates, and number of children, coverage is provided for, by completing the “Insurance Verification Form”.** If you are renting, we need a copy of your landlord’s Fire Insurance.
- \_\_\_\_\_ i. I will provide the department with the names, addresses, phone numbers, and parents’ names for 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 \_\_\_\_\_