NOTE: All accreditation forms must be completed and uploaded via the NAFCC Accreditation Portal to be processed

Candidate - First Name _____Last Name _____

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.

NAFCC
National Association for Family Child Care

Eligibility Criteria

- ☐ 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

Application Requirements

- ☐ Application
- ☐ Application Fee
- ☐ Current NAFCC Membership (if paying discounted fees)
  - ☐ Provider
  - ☐ Co-Provider
- ☐ Current License
- ☐ Health Assessment Form (within 2 years)
  - ☐ Provider
  - ☐ Co-Provider
  - ☐ Assistants
- ☐ TB Screening Form (within 2 years)
  - ☐ Provider
  - ☐ Co-Provider
  - ☐ Assistants
- ☐ Current First Aid and Pediatric CPR
  - ☐ Provider
  - ☐ Co-Provider
  - ☐ Assistant
- ☐ State and Federal Background Checks (within 3 years)
  - ☐ Provider
  - ☐ Co-Provider
  - ☐ Assistant
  - ☐ Adults 18+ Living in FCC Home
- ☐ Training Log and Verification (within 3 years)
  - ☐ Provider
  - ☐ Co-Provider

NOTE: All accreditation forms must be completed and uploaded via the NAFCC Accreditation Portal to be processed

NAFCC Accreditation Application

Candidate Information

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...** ☐English ☐Spanish **I need a bilingual observer** ☐Yes ☐No

☐ I am going through NAFCC Accreditation with an Agency/Project/Mentor.

Agency/Project Name/Mentor_____

Contact Person_____Address_____

Phone_____ Email_____

Please complete this section if you are receiving technical assistance or financial assistance/re-imbursement.

Are you currently an individual member of NAFCC?

☐ Yes ☐ No
☐ Membership fee included ($45)

Are you over 21 years of age?

☐ Yes
☐ No

I am applying for...

☐ 1st Accreditation ☐ Re-accreditation

Most current accreditation exp. ____/____/____

I have been accredited _____ times?

Education (check all that apply): ☐ Less than High School ☐ High School Diploma ☐ GED ☐ Some College

☐ Associate Degree_____ Year Obtained_____
☐ Bachelors Degree_____ Year Obtained_____
☐ Masters Degree_____ Year Obtained_____
☐ Doctorate Degree_____ Year Obtained_____

☐ 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?

☐ Less than 12 mos. How many mos.? _____
☐ 12 mos-2 yrs. ☐ 3-5 yrs.
☐ 5-10 yrs. ☐ 11-20 years ☐ 20+ yrs.

How many children are enrolled in your program?_____

How many of those children live outside your home?_____

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?

☐ Yes ☐ No

Is your family child care program regulated?

☐ Yes ☐ No
☐ Licensed ☐ Registered
☐ Certified ☐ Not available

Have you had any formal complaints or areas of non-compliance against your family child care home in the past three years? ☐ Yes ☐ 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.

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Candidate - First Name _____Last Name _____

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.

NAFCC
National Association for Family Child Care

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.

FOR TRAINING PURPOSES ONLY

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

NOTE: All accreditation forms must be completed and uploaded via the NAFCC Accreditation Portal to be processed

Candidate - First Name _____Last Name _____

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

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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? ☐ Yes ☐ No ☐ Membership fee included ($35)		**Are you over 21 years of age?** ☐ Yes ☐ No
Education (check all that apply): ☐ Less than High School ☐ High School Diploma ☐ GED ☐ Some College ☐ Associate Degree_____ ☐ Bachelors Degree_____ ☐ Masters Degree_____ ☐ Doctorate Degree_____ ☐ Current Family Child Care CDA (Child Development Associate)		
How long have you taken care of children in a home environment for pay? ☐ Less than 18 mos. How many mos.? _____ ☐ 18 mos-2 yrs. ☐ 3-5 yrs. ☐ 5-10 yrs. ☐ 11-20 years ☐ 20+ yrs.		
Are you on site and actively involved with children at least 60% of the hours your program is open? ☐ Yes ☐ No		

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Candidate - First Name ____________________________ Last Name _____________________________

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

Program Information							
☐ **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

Candidate - First Name ________________________ Last Name ________________________

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

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Candidate - First Name _____Last Name _____

A d d i t i o n a l I n f o r m a t i o n
Is there anything else that NAFCC and the observer should know to be prepared to observe your program. For example, if there are other adults in the program, do you need to give a better description of their role or is there another program in your home that is separate from yours?

Candidate - First Name _____ Last Name _____

Child Enrollment Information

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: Days M	T	W	T	F	S	S	Hours	Orig. Enroll. Date	Sibling's 1st Name	Prov. Child Yes/No
(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 **this page only**.	M-	T-	W-	Th-	F-	S-	Su-

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Candidate - First Name _____Last Name _____

Child Enrollment Information

Page 2

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

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

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Candidate - First Name _____Last Name _____

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.

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Candidate - First Name _____Last Name _____

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

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Candidate - First Name _____Last Name _____

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+

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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 #	Non-Member
☐ $45 **Membership Renewal Fee**	☐ $735 **Application Fee**
☐ $525 **Application Fee**	☐ $150 **Co-Provider Fee**
☐ $100 **Co-Provider Fee**	
Total amount $_____	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