MARYLAND STATE DEPARTMENT OF EDUCATION
DIVISION OF EARLY CHILDHOOD - OFFICE OF CHILD CARE
200 West Baltimore Street, 10th Floor, Baltimore, Maryland 21201

FAMILY CHILD CARE PROVIDER GRANT PROGRAM APPLICATION

INSTRUCTIONS:
Complete this application form, attach all required documentation, and mail it to the Office of Child Care at the above address. Complete all information in the spaces provided. All applications must be accompanied by required documentation. Incomplete applications will be returned.

Applicant Name: _____
(Please type or print) Last First Middle Maiden

Social Security # (required) _____ County: _____

Mailing Address: _____
Number Street Apt. # (if applicable) City State Zip Code

Daytime Phone #: (_____) _____ Alternate Phone #: (_____) _____

E-mail: _____ Fax #: _____

Address of Registered Family Child Care Home if different than above:

_____

_____

Family Child Care Provider Registration #: _____(attach copy of current registration)

Please check which one or more of the priority groups you will care for:

☐ Special Needs ☐ Purchase of Care ☐ Infants ☐ Toddlers

Please include a copy of your MOST RECENT TAX FORM (S) for proof of COMBINED ANNUAL FAMILY INCOME of all persons residing in your home:_____

NUMBER OF PERSONS RESIDING IN YOUR HOME: # of Adults:_____ # of Children:_____

APPLICATION TYPE (check only one)	☐ **FIRST APPLICATION** ☐ **RE-APPLICATION**
REQUIREMENT	**CLARIFICATION**
Receipts for all items you are requesting reimbursement for.	• Receipts must include: vendor name, date of purchase, item description and amount paid. • Copies of the receipts are preferred as long as they are still readable. • Unreadable receipts will not be reimbursed. • Canceled checks will be accepted if both sides of the check are copied. • ITEMS FOR REIMBURSEMENT MUST BE LISTED ON PAGE 2 OF THIS APPLICATION.
Current Family Child Care Center License	• Copy of current Maryland Child Care Registration.

APPLICATION CONTINUED ON THE OTHER SIDE

REMINDER: INCOMPLETE APPLICATIONS WILL BE RETURNED.

STATEMENTS AND ASSURANCES

Initial each item to indicate that you understand and agree with each statement.

- I affirm that all information on this application and all attached documentation are true and correct. (_____)
- I understand that giving a false statement will result in the denial of this application and recoupment of any funds disbursed as a result of this application. (_____)
- I understand that if I have had a child care license or registration suspended or revoked I may not be eligible to receive an award through this fund. (_____)
- I understand that if I am awarded funding through this program, I am required to:
    - Provide family child care, when registered, for at least one child from one of the priority groups for at least one year based on the requirements pursuant to COMAR 13A.14.09(_____)
    - Have not previously received funds from the Family Child Care Provider Grant Fund. (_____)
    - To provide child care services at this location for a minimum of one year after receiving the grant funds. (_____)
- I have attached all required information. (_____)

Signature: _____ Date: _____

Family Child Care Provider Grant – Receipts/items to be considered for award					
This section to be filled out by Provider (please print)				OCC Use Only	
RECEIPT #	STORE/VENDOR	ITEM	PRICE	ALLOWED	DISALLOWED
Example #1	Kmart	Outlet Plugs	4.96		
		First Aid Kit	10.95		
		Sales tax	0.80		

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