



**COVER SHEET**  
**Application For CCDF Child Care Provider -**  
**RELATIVE & IN-HOME**

**Please Read Carefully:**

Thank you for your interest in becoming a Child Care Development Fund (CCDF) Child Care Provider for families who may be eligible for child care assistance. Parents and families whose children receive subsidy benefits have the option to choose the type of child care provider they want to use, provided preliminary requirements are met by the child care provider.

**Overview:**

The CCDF program is a federal block grant for States, Tribes, and Territories and is a key resource to help increase the availability, affordability, and quality of child care services. CCDF supports low-income families, families receiving temporary public assistance, and those transitioning from public assistance, in obtaining child care services so they may work, attend training, or participate in educational activities.

The Bureau of Child Care Services (BCCS) is responsible for overseeing the CCDF Subsidy Program, which is overseen by the Division of Children's Wellness (DCW). The rules, policies and procedures are based on federal and state/territorial laws, policies and procedures.

All child care providers who participate in the CCDF Program must meet the eligibility and application requirements. These include but are not limited to the pre-service orientation of health and safety training coordinated by BCCS, Child Care Licensing Office and other certified trainers. **(Refer to Appendix A)** An initial inspection by the Child Care Licensing Officer and/or BCCS Representative will be conducted to ensure that all requirements are met.

You must complete the attached application and submit it along with the required documents to: DPHSS, Division of Children's Wellness, Bureau of Child Care Services, CCDF Provider Registration Section, Suite 15, Castle Mall, University Drive, Mangilao, Guam 96913, or via email to [childcare@dphss.guam.gov](mailto:childcare@dphss.guam.gov).

The list below are document requirements for Licensed Child Care Facilities & Licensed Group Child Care Homes. Your application must include the following documents in order to validate the clearances conducted by the respective Agency. **If you have submitted these documents to BCCS-Child Care Licensing, a clearance form must be obtained from the licensing officer and routed to BCCS-CCDF Provider Registration.**

NO.	TYPE OF DOCUMENT
1	Completed CCDF Child Care Provider Application
2	Child/Children must be under CCDF Child Care Assistance
3	Compliant Validation Form Completed by BCCS (See Appendix - 2)
4	Completed Consent for Disclosure of Client Information Form
5	Health Certificate (For Primary ONLY)
6	Police Clearances (issued within the last 30 days): (for all adults in household)
7	Court Clearances (issued within the last 30 days): (for all adults in household)
8	With Signature Consent to Run National Sex Offender Registry Check
9	Completed Vendor Application Form

Please be advised that DPHSS-BCCS is also required to implement comprehensive background clearance requirements as mandated in the Child Care Development Block Grant Act of 2014 (CCDBG), for all child care staff members (including prospective child care staff members of all licensed regulated, licensed-exempt, or registered child care providers) and all child care providers eligible to deliver services are established, which is essential to ensure the health and safety of children in care.

Therefore, pending the full implementation of the CCDBG Act, all License-Exempt Child Care Providers must comply with the minimum health & safety requirements and checklists identified and defined by BCCS Provider Registration as part of the health and safety standards and other requirements **prior** to the receipt of any CCDF funds. The DPHSS, BCCS will validate your clearances accordingly.

Upon the full implementation of the CCDBG Act, all child care providers will be notified and are subject to comply with these standards.

You are also advised that the law(s) gives reasons for revocation of your ability to receive CCDF payment if it is determined the child care provider (applicant) has given:

- False statements on an application or any records required by the Department of Public Health, Division of Children's Wellness, Bureau of Child Care Services, CCDF Provider Registration.
- If there are credible allegations that the provider has committed fraud, or if criminal charges / charges of fraud have been filed against you, your CCDF eligibility will be revoked.

*[10 GCA: Health & Safety; Chapter 2 – Division of Public Welfare, §2107. Frauds: Penalties]*

Once you have met the requirements and have been approved by DPHSS-BCCS, CCDF Provider Registration, you are required to take a **one-time Provider-Orientation**. A BCCS representative will contact you to schedule an orientation. If you have any questions, please contact our Office at (671) 735-7344.



**Department of Public Health & Social Services  
APPLICATION FOR CCDF CHILD CARE  
PROVIDER**

**I. APPLICATION INFORMATION:**

<b>Name of Applicant:</b>	
<b>Name of Facility (if applicable):</b>	
<b>Physical Address of Child Care Facility or Home:</b>	
<b>Mailing Address (Postal Box, City/Zip Code)</b>	
<b>Contact Nos. (Business/Cell/Home)</b>	
<b>Email Address:</b>	

**II. ORGANIZATION'S CHILD CARE INFORMATION**

<b>Government of Guam Vendor ID #:</b>	<b>TIN/SS #:</b>
<b>Type of Child Care Provider (select one)</b>	
<input type="checkbox"/> Licensed-exempt Provider (In-Home) <input type="checkbox"/> Licensed-exempt Provider (Relative)	
Other: _____	

**Provide the age(s) and number of children per age group below:**

DESCRIPTION	INFANT	TODDLER	PRE-SCHOOL	SCHOOL-AGE
AGE				
NUMBER OF CHILDREN				

DAYS OF OPERATION	MON.	TUES.	WED.	THURS.	FRI.	SAT	SUN
<b>HOURS</b> FROM:							
Twenty-four (24) Hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HOURS</b> FROM:							
<p>By my signature below, I hereby certify all documentation submitted is true and correct to the best of my knowledge. I understand that I will be visited by a representative from DPHSS, BCCS. The visit will be scheduled after all required documentation is received by the BCCS. The verification visit will confirm compliance of the required CCDF Child Care Provider requirements for receipt of CCDF childcare voucher dollars. If the provider eligibility standards are met with satisfaction, I will be certified by the DPHSS, BCCS.</p>							
Signature of Applicant/Title				Date signed (month, day, year)			



Application for CCDF Child Care Provider  
APPENDIX - 1

**HEALTH & SAFETY STANDARDS:**

You must complete a pre-service orientation and annual in-depth training of or related to the following health & safety standards:

1. Prevention & control of infectious diseases (including immunization)
2. Prevention of sudden infant death syndrome & the use of safe-sleep practices
3. Administration of medication, consistent with standards for parental consent
4. Prevention of and response to emergencies due to food and allergic reactions
5. Building & physical premises safety, including the identification of and protection, from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic
6. Prevention of shaken baby syndrome, abusive head trauma and child maltreatment
7. Emergency Preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event (such as violence at a child care facility) within the meaning of those terms under section 602(a)(1) of the Robert T Stafford Disaster Relieve & Emergency Assistance Act. EPRP must include procedures for evacuation; relocation; shelter-in-place and lockdown; staff and volunteer training and practice drills; communications and reunification with families; continuity of operations; and accommodations for infants and toddlers, children with disabilities, and children with chronic medical conditions
8. Handling and storage of hazardous materials and the appropriate disposal of bio-contaminants
9. Precautions in transporting children (if applicable)
10. Pediatric first aid and cardiopulmonary resuscitation (CPR) certification
11. Recognition & reporting of child abuse and neglect
12. Child Development
13. 15 Training Hrs. (Annually)

For additional information regarding the CCDF Child Care Provider requirements, you may contact the Bureau of Child Care Services (BCCS) at (671) 735-7344 or email [childcare@dphss.guam.gov](mailto:childcare@dphss.guam.gov) or visit our website at [guamchildcare.com](http://guamchildcare.com).

Application for CCDF Child Care Provider  
APPENDIX - 2



**Bureau of Child Care Services (BCCS)**  
*License Exempt-Relative Care Validation Checklist*

Standards	YES	NO	NA	COMMENTS
Is the provider caring for a child with special needs? • Yes • No If so, are accommodations being made to meet the child's needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indoor and outdoor areas must be maintained in a safe manner (ex: no sharp objects near children, the outdoor area must be safe for children, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
General documents needed: valid health certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Each child must have their own bed, cot, mat, or pad, when sleeping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The home has a working telephone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The home has a working smoke detector (on each level if applicable), fire extinguisher, and a First Aid Kit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The home must have a secondary exit in case of fire or other emergencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Each outlet, reachable by children, must have a proper cover.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hazardous materials for example cleaning products, antifreeze, insecticides, aerosol sprays, etc. properly handled and stored, and bio-contaminants (like dirty diapers) are properly disposed of.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At least one proper handwashing poster is posted near a sink.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The provider has an emergency preparedness plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Culture, language, and developmental needs are promoted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The provider must have a child file on hand containing the child's allergies, medication list (if applicable), dietary needs, and medication file listing: when medication is administered, the dosage, and parental consent <b><u>BEFORE</u></b> administering such medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The provider must have a folder containing their credentials (to ensure 15 hours of annual training requirement-provider must have taken the Health & Safety Orientation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If applicable, the provider must have a valid driver's license when and if transporting children in their care and follow all safety standards when transporting children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Relative Provider: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

BCCS Staff: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



LOURDES A. LEON GUERRERO  
GOVERNOR, MAGA'HAGA'

JOSHUA F. TENORIO  
LT. GOVERNOR, SIGUNDO MAGA'LÁHI

ARTHUR U. SAN AGUSTIN, MHR  
DIRECTOR

LAURENT SF DUENAS, MPH, BSN  
DEPUTY DIRECTOR

TERRY G. AGUON  
DEPUTY DIRECTOR

**BUREAU OF SOCIAL SERVICES ADMINISTRATION  
DIVISION OF CHILDREN'S WELLNESS  
CONSENT FOR DISCLOSURE OF CLIENT INFORMATION**

This information is to be released from records whose confidentiality is protected by Federal law regarding right to privacy, which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information will not be sufficient for this purpose.

1. Name of Program to Give Information: <b>DEPARTMENT OF PUBLIC HEALTH &amp; SOCIAL SERVICES, CHILD PROTECTIVE SERVICES</b>
2. Name of Person or Organization to Receive Information: Requestor Name: Requesting Organization: Email Address: Mailing Address: Contact Number:  CC: DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES, HOME EVALUATION & PLACEMENT SERVICES
3. Name of Client / Date of Birth (Print):
4. State/s or Territories of Residence in the last five (5) years, if different.
5. Purpose or Need for the Disclosure (Please be very specific): <b>VERIFICATION OF ANY REFERRALS OF CHILD ABUSE/NEGLECT ON THE INDIVIDUAL</b>
6. Extent or Nature of Information to be Disclosed (Please be very specific): <b>OUTCOME OF INVESTIGATION, INCLUDING FINDINGS AND RECOMMENDATIONS, IF APPLICABLE</b>

This Consent shall be effective immediately and shall remain in effect for a duration not to exceed ninety (90) days unless dated otherwise (date): \_\_\_\_\_

Signature of Client/Guardian/Parent	Title & Signature of Person Requesting Information
Date: _____	Date: _____

The client may revoke this Consent for Disclosure of Client Information at any time by completing the following information.

I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE PERSON OR ORGANIZATION ABOVE AS OF: \_\_\_\_\_

Signature of Client/Guardian/Parent \_\_\_\_\_ Date: \_\_\_\_\_



# GOVERNMENT OF GUAM

DEPARTMENT OF ADMINISTRATION

DIVISION OF ACCOUNTS

mail: ATTN: Division of Accounts, P.O. Box 884, Hagatna, GU 96932 \* fax: 671-472-8483



## VENDOR RECORD / EFT ESTABLISHMENT REQUEST

To: Accounts Payable Section

From: \_\_\_\_\_

Subject: Request for establishment of vendor number or change of vendor record.

This is a request for the establishment of vendor number or the change of vendor record for the following:

NEW VENDOR

CHANGE OF VENDOR RECORD

Name \_\_\_\_\_

Name \_\_\_\_\_

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

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

City State Zip Code \_\_\_\_\_

City State Zip Code \_\_\_\_\_

### OTHER REQUIRED INFORMATION

Taxpayer ID No./Soc Sec No: \_\_\_\_\_

Type of Product / Svc: \_\_\_\_\_

Contact Number (primary): \_\_\_\_\_

Contact No.(other): \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Check all Applicable:  Petty Cash Custodian

Business License  Proper identification

TRAVEL  EMPLOYEE

Form W-9 <https://www.irs.gov/pub/irs-pdf/fw9.pdf>

### Electronic Funds Transfer (EFT) Information<sup>1</sup>

Type of Account:  Checking: Attach Voided Check or Personalized Deposit Slip

Savings: Attach Copy of Current Bank Statement

Bank Name and Address \_\_\_\_\_

Account Number Routing Number \_\_\_\_\_

<sup>1</sup> The undersigned confirms its account number and title named above and hereby acknowledged that the undersigned has no enforceable right in, or to Department of Administration. The undersigned also has read and understood 4 GCA §8169 which state:

*Any person who knowingly makes any false statement or falsifies or permits to be falsified, any record or records of this system, in any attempt to defraud the system, is guilty of a misdemeanor and shall be punishable therefore under the laws of the government of Guam, and the system shall have the right to recover any payments made under false representations.*

Existing Vendor Number

**NOTE: Please attach all required supporting documentation. Incomplete requests will not be processed and may create unnecessary delays in the vendor establishment process.**

VENDOR APPLICANT'S SIGNATURE

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

### DEPARTMENT OF ADMINISTRATION

Vendor Number

Established by:

Signature

Date