

OFFICE USE ONLY
Licensing specialist: _____

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING (OCCL)

**FAMILY CHILD CARE HOME
RELOCATION LICENSE APPLICATION**

**Please Print
all responses.**
Date received: _____

License number: _____ License expiration date: ____/____/____

SECTION A – Identification

Applicant name: _____ Date of birth: _____ Race: _____

Alias, maiden, or married names this person has used: _____

Location address: _____
(street) (city) (county) (state) (zip)

Applicant cell phone #: _____ Location phone #: _____

Email address: _____ Fax #: _____

Entity Information (optional)

The “entity” is the individual, LLC, or corporation that is responsible for and has authority over the operation of the facility. If there is an entity, the applicant must still have responsibility for the facility, reside in the facility, provide the child care, and control the space. If no entity has been formed, check “individual” and leave the rest of this section blank.

Individual Corporation

Entity name: _____ Entity type: Limited liability company (LLC)

Doing business as/facility name: _____

Entity address: _____
(street) (city) (state) (zip)

1. If the entity is an LLC, provide on a separate page a name, address, and phone number for the managing member.
2. If the entity is a corporation, provide on a separate page a name, address, and phone number for each corporate officer.
3. Please submit: certificate of incorporation or LLC, if applicable and a Delaware state business license or proof of non-profit status (for example, letter of tax-exempt status or 501(c)(3) documents).

SECTION B – Additional Information

Household member(s) other than the applicant (anyone staying in the home for more than 30 days within a year, or whose current driver’s license/state ID is issued to the address listed on this application)

Full name	Alias, maiden, or married names this person has used	Date of birth	Race	Gender

SECTION B – Additional Information, continued

Substitute(s)

Full name	Alias, maiden, or married names this person has used	Date of birth	Race	Gender	Emergency or non-emergency use

CHU contact

Please provide the email at which you prefer to receive the fingerprinted background check results from the Criminal History Unit (CHU). The results will contain confidential information about each person’s eligibility for employment or to reside at a licensed child care facility.

CHU contact name: _____ Email: _____

SECTION C – Current Enrollment

Child’s name (FIRST NAME ONLY)	Date of birth	Days attending	Hours attending each day
Example: Dante	5/22/10	Monday - Friday	8:00 a.m. - 5:00 p.m.
Example: Kate	11/6/09	Monday - Friday	7:00 a.m. – 8:15 a.m. 3:15 p.m. – 5:45 p.m.

SECTION D – Program Information

Hours of operation: _____ a.m. – _____ p.m. or a.m. (circle one) _____ p.m. – _____ p.m.

Days of operation: M T W Th F Sa Su

Months of operation: January to December August to June _____ to _____

Ages of children accepted: (Use “kindergarten” for 5-year-olds attending kindergarten. Otherwise, use exact ages.)
Example: From 6 weeks to 12 years From _____ to _____

Program components:
 Purchase of Care Transportation: field trips daily other _____
 Food program (CACFP) agency: _____ Other (specify): _____

