

OFFICE USE ONLY

Licensing specialist: \_\_\_\_\_

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

**CHILD PLACING AGENCY**  
**RENEWAL/RELOCATION LICENSE APPLICATION**

**Please print  
all responses.**

Date received: \_\_\_\_\_

License expiration date: \_\_\_/\_\_\_/\_\_\_ License number: \_\_\_\_\_

Check application type:  Renewal  Relocation

**Before completing this application, review *DELACARE: Regulations for Child Placing Agencies*. Answer all applicable questions and attach all required application materials/documents.**

- The “applicant” is the individual owner if not a corporation or limited liability company (LLC). For a corporation, it is the president. For an LLC, it is the managing member. This individual must sign the application or provide written authorization allowing the chief administrator to sign.
- The “agency” is the legal name by which the agency will be known.
- The “chief administrator” is the agency staff member designated by the licensee or governing body as having day-to-day responsibilities for the overall administration and operation of the agency. This person assures the care, treatment, safety, and protection of child clients and meets the qualifications in the regulations.
- The “entity” is the corporation or LLC that is responsible for and has authority over the operation of the agency.

**SECTION A – Identification**

**Applicant name:** \_\_\_\_\_ Will individual be on-site or have interaction with children in care?  Yes  No

Cell phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Home address: \_\_\_\_\_  
(street) (city) (state) (zip)

**Agency name:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (county) (state) (zip)

**Chief administrator name:** \_\_\_\_\_ Will individual be on-site or have interaction with children in care?  Yes  No

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

Cell phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip)

**Parent organization, if applicable:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip)

**CHU contact**

Please provide a contact person and email 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.

**CHU contact name:** \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION B – Entity Information (as applicable)**

**If there is no entity, check “individual” and skip the related entity information.**

Submit one:  
 Delaware State business license  
 -or-  
 Proof of non-profit status (for example, letter of tax-exempt status or 501(c)(3) documents)

Entity name: \_\_\_\_\_ Entity type:  Individual  Corporation  
 Limited liability company (LLC)

Entity address: \_\_\_\_\_  
 (street) (city) (state) (zip)

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

1. If entity is an LLC, list below a name, address, email, and phone number for the managing member.  
 2. If entity is a corporation, list below a name, address, email, and phone number for each corporate officer.

For corporation: officers For LLC: managing member	Title	Address and email	Will this person be on-site or have access to children?	
			No	Yes

**SECTION C – Licensure Background**

List any other agency locations in Delaware that provide child-placing services:

Name	Address	Telephone

**SECTION D – Staffing** (attach an additional sheet if needed)

Name	Position/Title	Date of birth	Race*	Works 30 or more hours/week
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
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				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**\*Race is a DSCYF database required field. Select a designation below to complete this field.**

AI=American Indian/Alaskan Native    B=Black/African American    NH=Native Hawaiian/Pacific Islander  
 A=Asian    H=Hispanic    W=White    ND=Not Determined

**SECTION E – Program Information**

**Service(s) provided:**     Foster care     Adoption services

**Area(s) served:**     New Castle County     Kent County     Sussex County     statewide

**Sex(es) of children to be served:**     Male     Female

**Ages of children to be served**

Example: From 4 years to 17 years

From \_\_\_\_\_ to \_\_\_\_\_

Do you anticipate changes in services offered in the next 12 months?     Yes     No

**If the answer is “Yes,” what is the anticipated change?** \_\_\_\_\_



