

Section 1 - Program Information

SITE NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

PHONE NUMBER _____ FAX NUMBER _____

FEIN _____ IDCFS LICENSE NUMBER _____

Please include a copy of your IDCFS License with your application.

IF SERVING CHILD CARE ASSISTANCE PROGRAM (CCAP) CHILDREN YOU MUST PROVIDE YOUR 15 DIGIT PROVIDER NUMBER(S) YOU RECEIVE PAYMENT UNDER. FAILURE TO PROVIDE THIS WILL RESULT IN MISSED ADD-ONS, IF AVAILABLE.

PROVIDER NUMBER(S) _____

This number can be found directly after your name on the CCAP documentation.

On-Site Contact Person:

NAME _____

REGISTRY MEMBER ID _____ EMAIL _____

Section 2 - Site Information

Days and Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time							
End Time							

Year Schedule: (check one)

- FULL YEAR (serving children at least 47 weeks) SUMMER ONLY
 SCHOOL YEAR ONLY OTHER PART YEAR (serving children less than 47 weeks, but not School Year Only or Summer Only)

Check the box(es) for each source of funding that this site receives: (check all that apply)

- PARENT TUITION/FEES PREVENTION INITIATIVE (ISBE/CPS)
 CHILD CARE ASSISTANCE PROGRAM (CCAP) PRESCHOOL FOR ALL (ISBE/CPS)
 HEAD START/EARLY HEAD START DEPARTMENT OF FAMILY AND SUPPORT SERVICES (DFSS) CITY OF CHICAGO

TOTAL # CLASSROOMS AT SITE: _____

1/2 DAY CLASSROOMS/SESSIONS _____ # FULL DAY CLASSROOMS/SESSIONS _____

CURRENT ENROLLMENT: TOTAL HS (AGES 0 – 3) _____ TOTAL HS (AGES 3 – 5) _____

Section 3 - Certification Acknowledgement and Application Authorization

1. Please submit a copy of your program’s current valid accreditation certificate from a state approved accrediting body.

Please check one:

- AdvancED ACCREDITATION
- AMERICAN MONTESSORI SOCIETY (AMS) ACCREDITATION
- COUNCIL ON ACCREDITATION (COA) EARLY CHILDHOOD PROGRAMS
- NATIONAL ACCREDITATION COMMISSION (NAC)
- NATIONAL ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN (NAEYC)
- NATIONAL EARLY CHILDHOOD PROGRAM ACCREDITATION (NECPA)

I certify that all information provided herein is true and accurate. By my signature below I authorize INCCRRA to verify any information and documents submitted as part of this application. I understand that false or misleading information may constitute grounds for denial of this application. I understand that my ExceleRate Circle of Quality, if awarded, will be published on the ExceleRate public website, and that aggregated site information may be used for research/evaluation purposes.

- Please check that you acknowledge and agree to have at least 30% of Program Teaching Staff apply for Gateways Credentials.*

SIGNATURE, PROGRAM AUTHORIZED OFFICIAL: _____ DATE: _____

PRINT NAME: _____ TITLE: _____