

**Clear Form**

DHS-8206A-ENG 11-22

OFFICE OF INSPECTOR GENERAL - LICENSING DIVISION

Program Plan for Special Family Child Care

***\*IMPORTANT:*** If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.



**Print Blank Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROVIDER/PROGRAM NAME | | | | |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| EMAIL ADDRESS | PHONE NUMBER | LICENSE CLASS | | |

**Outdoor play and travel**

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| --- |
| IS THERE AN IDENTIFIED OUTDOOR PLAY SPACE ADJACENT TO THE PROGRAM WITH AT LEAST 50 SQ FEET PER CHILD IN ATTENDANCE?  Yes  No |
| WILL THE OUTDOOR PLAY SPACE BE SHARED?  Yes  No |
| OUTLINE YOUR PLAN FOR OUTDOOR SUPERVISION: |
| WILL YOUR PROGRAM INCLUDE TRAVEL OFF-SITE?  Yes  No |

**Toileting and diaper changing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| IS THERE A BATHROOM WITHIN THE ROOM THAT WILL BE THE PRIMARY CARE SPACE? | Yes |  | No |  |
| IS THERE A SINK IN THE SPACE FOR WASHING HANDS AFTER DIAPERING AND FOR MEAL TIMES? |  | Yes |  | No |
| OUTLINE IN DETAIL HOW YOU WILL MAINTAIN REQUIRED SUPERVISION OF ALL CHILDREN DURING TOILETING TIME: | | | | |
| WHERE WILL YOU CHANGE DIAPERS? | | | | |
| WHAT IS THE PLAN FOR DISPOSAL OF WET OR SOILED DIAPERS? | | | | |

**Meals and snacks**

|  |
| --- |
| WILL YOU PREPARE FOOD ON SITE?  Yes  No |
| WILL THE CHILDREN EAT IN THE PRIMARY CHILD CARE SPACE?  Yes  No |
| WILL ANYONE ELSE HAVE ACCESS TO THAT SPACE AT THAT TIME, INCLUDING OTHER LICENSED PROGRAMS?  Yes  No |

**Public building information**

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| IS THE BUILDING USED BY OTHERS?  Yes  No |
| WILL THE IDENTIFIED CHILD CARE SPACE BE USED BY OTHERS WHEN CHILD CARE IS CLOSED?  Yes  No |

**Multiple child care programs in the same building**

|  |
| --- |
| WILL OTHER CHILD CARE PROGRAMS BE OPERATING AT THE SAME TIME IN THE SAME BUILDING? Yes No |

**Program staffing**

What days and hours will your program operate?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
| WILL YOU USE STAFF/VOLUNTEERS TO ASSIST YOU IN THE OPERATION OF YOUR PROGRAM?  Yes  No | | | | | | |

**Additional safety measures**

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| GIVEN THAT YOU ARE OPERATING A PROGRAM IN A LOCATION OTHER THAN WHERE THE LICENSE HOLDER LIVES, PLEASE OUTLINE ANY ADDITIONAL MEASURES YOU WILL USE TO ENSURE THE SAFTEY OF ALL CHILDREN IN CARE: |

**Daily schedule**

|  |
| --- |
| DESCRIBE THE PROPOSED SCHEDULE FOR THE DAY FROM TIME OF OPENING TO THE END OF THE DAY AND CLOSING OF THE PROGRAM: |

**Signature**

By checking "I agree" and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

|  |  |  |
| --- | --- | --- |
| I agree | PROVIDER'S ELECTRONIC SIGNATURE (type name) | DATE |

**Please attach supporting documentation such as photos or floor plans if available.**