

FAMILY CHILD CARE (FCC) PROVIDER APPLICATION

For use of this form, see AR 608-10

DATE REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012.
PRINCIPAL PURPOSE: Information is used by DA personnel to identify potential FCC providers and services to be provided. Provide household information, background and references.
ROUTINE USES: No information is disclosed outside DOD.
DISCLOSURE: Disclosure of requested information is voluntary, however, if information is not provided certification of the candidate may be denied.

Name (Last , First, MI)	Birth date	SSN:
Home address:		Telephone #
Email address:		Sponsor's Military address & phone#

PROVISION OF SERVICES

As an FCC provider you need to be available from Monday thru Friday from 0600 to 1800 (including training holidays) and be able to meet at least one of the community demands for care: Infant care, Extended hours care, Special needs care.

You must have a High school diploma _____ or a GED _____ (Check one please) Date: _____
 Degree yes/no (circle one) in: _____ Date: _____

Have you had experience working with children other than your own (if yes, describe).

How did you find out about becoming a Family Child Care Provider (Website, Flyers etc)?

You can not hold another job while being certified as an FCC provider (Ex: AAFES, Commissary, Home Business like Avon, Pampered Chef etc.)

HOUSEHOLD INFORMATION

Please list all Family members living with you: _____

Do you have children living with you who are 12 years old and over? If yes, we are required to do background checks on them.

Please give the names and addresses of three persons (other than relatives) whom the Army may contact for references. They should know you personally and be willing to testify to your character, ability and experience.

Full Name	Address	Phone number

STATEMENT OF APPLICATION

I hereby apply to become certified by the Army as a provider for the USAG Baumholder FCC Home System. I understand that in order to qualify, I, my family, and my home must meet all standards contained in AR 608-10 and all installation requirements pertaining to the care of children. I further understand that upon my certification, the Army will refer my name to potential patrons who will then contact me directly regarding services for their children. I will not provide child care services for any child not centrally registered with the USAG Baumholder CYS System.

Date	Signature
------	-----------

MILITARY POLICE RECORD CHECK
(AE Reg 190-45)

1. Control number

The Military Police Record Check is intended to be completed within 72 hours to allow for researching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Privacy Act Statement

AUTHORITY: Title 10, United States Code, Section 3013; 18 USC 921-922; 28 USC 534; DODI 1030.01; AR 190-45; and E.O. 9397.

PRINCIPAL PURPOSE: To conduct military police record checks using military police reporting systems. Military police record checks are conducted only for authorized reasons (for example, childcare and youth program providers, access control, unique or special duty assignments, security clearances). Any information released must be restricted to that necessary and relevant to the requester's official purpose.

ROUTINE USES: Information collected on this form may be released to law enforcement agencies engaged in the investigation or prosecution of a criminal act or the enforcement or implementation of a statute, rule, regulation or order, and to any component of the Department of Justice for the purpose of representing the DOD.

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the inability of this office to conduct the requested checks.

This data is FOR OFFICIAL USE ONLY and will be maintained and used in strict confidence in accordance with Federal law and regulations. Knowingly and willfully making a false statement on this document may be punishable by fine or imprisonment or both. All information provided by you, which possibly may reflect adversely on your past conduct and performance, may have an adverse effect on you in your goal of employment.

Section I (to be completed by requester)

2. Name (Last, first, middle)		3. Sex	4. Place of birth	
		Male <input type="checkbox"/>	a. City	
		Female <input type="checkbox"/>	b. State/ Country	
5. Date of birth (YYYYMMDD)	6. Social security/Passport no.	7. Telephone no.	8. E-mail address	

9. I hereby consent to the release of all files produced from the records check.	Signature (requester's signature not required if submitted by authorized agency)
---	---

Section II (to be completed by requesting agency)

10. Reason for request FCC application from Spouse			
11. Name and agency of requester Hildegard Bragg	12. Grade	13. E-mail address Hildegard.Bragg2.ln@mail.mil	14. Signature

Section III (to be completed by military police or other agency)

15. Findings (derogatory information on record)
No <input type="checkbox"/> Results
Yes <input type="checkbox"/>

This is to certify that the above data is correct and true according to the record on file in this office. This information is confidential and cannot be used in any other manner except for official purposes.

16. Printed name and title	17. Date (YYYYMMDD)	18. Signature
-----------------------------------	----------------------------	----------------------

MILITARY POLICE RECORD CHECK (AE Reg 190-45)	1. Control number
--	--------------------------

The Military Police Record Check is intended to be completed within 72 hours to allow for researching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Privacy Act Statement

AUTHORITY: Title 10, United States Code, Section 3013; 18 USC 921-922; 28 USC 534; DODI 1030.01; AR 190-45; and E.O. 9397.
PRINCIPAL PURPOSE: To conduct military police record checks using military police reporting systems. Military police record checks are conducted only for authorized reasons (for example, childcare and youth program providers, access control, unique or special duty assignments, security clearances). Any information released must be restricted to that necessary and relevant to the requester's official purpose.
ROUTINE USES: Information collected on this form may be released to law enforcement agencies engaged in the investigation or prosecution of a criminal act or the enforcement or implementation of a statute, rule, regulation or order, and to any component of the Department of Justice for the purpose of representing the DOD.
DISCLOSURE: Voluntary; however, failure to provide the required information may result in the inability of this office to conduct the requested checks.

This data is FOR OFFICIAL USE ONLY and will be maintained and used in strict confidence in accordance with Federal law and regulations. Knowingly and willfully making a false statement on this document may be punishable by fine or imprisonment or both. All information provided by you, which possibly may reflect adversely on your past conduct and performance, may have an adverse effect on you in your goal of employment.

Section I (to be completed by requester)

2. Name (Last, first, middle)	3. Sex	4. Place of birth	
	Male <input type="checkbox"/>	a. City	
	Female <input type="checkbox"/>	b. State/ Country	
5. Date of birth (YYYYMMDD)	6. Social security/Passport no.	7. Telephone no.	8. E-mail address

9. I hereby consent to the release of all files produced from the records check.	Signature (requester's signature not required if submitted by authorized agency)
---	---

Section II (to be completed by requesting agency)

10. Reason for request FCC application from Sponsor of Applicant			
11. Name and agency of requester Hildegard Bragg	12. Grade	13. E-mail address Hildegard.Bragg2.ln@mail.mil	14. Signature

Section III (to be completed by military police or other agency)

15. Findings (derogatory information on record)	Results
No <input type="checkbox"/>	
Yes <input type="checkbox"/>	

This is to certify that the above data is correct and true according to the record on file in this office. This information is confidential and cannot be used in any other manner except for official purposes.

16. Printed name and title	17. Date (YYYYMMDD)	18. Signature
-----------------------------------	----------------------------	----------------------

**USAG Baumholder
Background Check Request Form**

The Behavioral Health and Alcohol and Substance Abuse Program record checks are intended to be completed within 72 hours to allow for researching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Privacy Act Statement

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Title 10USC, AR 215-3, AR 190-45, AR 600-85, AR 608-1, AR 165-1

PRINCIPAL PURPOSE: To conduct record checks using Military Treatment Facilities (MTF) reporting systems. MTF record checks are conducted only for authorized reasons (for example, childcare and youth program providers, access control, unique or special duty assignments, security clearances). Any information released must be restricted to that necessary and relevant to the requester's official purpose.

ROUTINE USES: Information collected on this form will be used to determine the applicants suitability to work or volunteer with children and youth.

DISCLOSURE: Voluntary. Failure to provide the required information may result in the inability of this office to conduct the requested checks.

This data is **FOR OFFICIAL USE ONLY** and will be maintained and used in strict confidence in accordance with Federal law and regulations. Knowingly and willfully making a false statement on this document may be punishable by fine or imprisonment or both. All information provided by you, which possibly may reflect adversely on your past conduct and performance, may have an adverse effect on you in your goal of employment.

Section I (to be completed by applicant)

Name (Last, First, middle) <i>SPOUSE</i>	Sex Male <input type="checkbox"/>	Place of birth City
	Female <input type="checkbox"/>	State/Country
Date of birth (YYYYMMDD)	Social Security Number	Telephone #
		Email address

I hereby consent to the release of all files produced from the records check.	Signature
---	-----------

Section II (to be completed by requesting agency)

Reason for request	Behavioral Health Check <input type="checkbox"/>
	ASAP Check <input type="checkbox"/>
Name and Agency of Requestor	Grade
E-mail address	Signature

Section III (to be completed by Behavioral Health or ASAP)

Findings (derogatory information on record) No <input type="checkbox"/> Yes <input type="checkbox"/>	Brief Summary of results- further information may be requested if a Program Review Board is held.
--	---

This is to certify that the above data is correct and true according to the record on file in this office. This information is confidential and cannot be used in any other manner except for official purposes.

Printed name and title	Date (YYYYMMDD)	Signature
------------------------	-----------------	-----------

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (<i>Last, First, Middle Initial</i>)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (<i>X one</i>)	
	<input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input checked="" type="checkbox"/> BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE <u>Baumholder Mental Health Clinic</u> TO RELEASE MY PATIENT INFORMATION TO:	
<i>(Name of Facility/TRICARE Health Plan)</i>	
a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS (<i>Street, City, State and ZIP Code</i>)
c. TELEPHONE (<i>Include Area Code</i>)	d. FAX (<i>Include Area Code</i>)
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (<i>X as applicable</i>)	
<input type="checkbox"/> PERSONAL USE <input type="checkbox"/> CONTINUED MEDICAL CARE <input type="checkbox"/> SCHOOL <input checked="" type="checkbox"/> OTHER (<i>Specify</i>) Background check <input type="checkbox"/> INSURANCE <input type="checkbox"/> RETIREMENT/SEPARATION <input type="checkbox"/> LEGAL	
8. INFORMATION TO BE RELEASED Background check for Baumholder	
9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION
	<input type="checkbox"/> DATE (YYYYMMDD) <input type="checkbox"/> ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:

- I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
- The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT <i>(if applicable)</i> self	13. DATE (YYYYMMDD)
---	--	----------------------------

SECTION IV - FOR STAFF USE ONLY (*To be completed only upon receipt of written revocation*)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

ADAPCP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION

For use of this form, see AR 600-85; the proponent agency is DCSPER.

SPOUSE

SECTION A - CONSENT

I, _____, this _____ day of _____, 19____,
(client's full name)

do hereby voluntarily consent to the release of the following information by USAG Baumholder ASAP
(name of installation ADAPCP)

pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitatiton, or research to USAG Baumholder

_____ for the purpose of _____
 completing a background check for _____

_____ namely,
 whether enrolled in ASAP or if any history of positive urinalysis test

(extent or nature of information to be disclosed)

SECTION B - EXPIRATION/REVOICATION

(Check applicable paragraph)

1. I understand that this consent automatically expires when the above disclosure action has been taken in reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at any time.

- Or -

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 6-9b(4)(b) and 6-10e(3), AR 600-85)

2. I understand that this consent automatically expires 60 days from today's date or when my present criminal justice system status changes to _____

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my participation in the ADAPCP, I cannot revoke this consent until there has been a formal and effective termination or revocation of my release from such confinement, probation, or parole.

SIGNATURE OF CLIENT		DATE
X		
NAME OF WITNESS <small>(Type or print)</small>	SIGNATURE	DATE
X	X	

SECTION C - APPROVAL AUTHORITY FOR RELEASE OF INFORMATION

NOTE: Other than the MEDCEN/MEDDAC Commander, approval authority for release of information may be delegated to the Program Physician or the Clinical Director.

In my judgment, the release of an evaluation of the present or past status of _____
(client's name)
 in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

NAME OF MEDCEN/MEDDAC COMMANDER OR DESIGNATED REPRESENTATIVE <small>(Type or print)</small>	DATE
SIGNATURE	

**USAG Baumholder
Background Check Request Form**

The Behavioral Health and Alcohol and Substance Abuse Program record checks are intended to be completed within 72 hours to allow for researching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Privacy Act Statement

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Title 10USC, AR 215-3, AR 190-45, AR 600-85, AR 608-1, AR 165-1

PRINCIPAL PURPOSE: To conduct record checks using Military Treatment Facilities (MTF) reporting systems. MTF record checks are conducted only for authorized reasons (for example, childcare and youth program providers, access control, unique or special duty assignments, security clearances). Any information released must be restricted to that necessary and relevant to the requester's official purpose.

ROUTINE USES: Information collected on this form will be used to determine the applicants suitability to work or volunteer with children and youth.

DISCLOSURE: Voluntary. Failure to provide the required information may result in the inability of this office to conduct the requested checks.

This data is FOR OFFICIAL USE ONLY and will be maintained and used in strict confidence in accordance with Federal law and regulations. Knowingly and willfully making a false statement on this document may be punishable by fine or imprisonment or both. All information provided by you, which possibly may reflect adversely on your past conduct and performance, may have an adverse effect on you in your goal of employment.

Section I (to be completed by applicant)

Name (Last, First, middle) <i>SPONSOR</i>	Sex Male <input type="checkbox"/>	Place of birth City
	Female <input type="checkbox"/>	State/Country
Date of birth (YYYYMMDD)	Social Security Number	Telephone #
		Email address

I hereby consent to the release of all files produced from the records check.	Signature
---	-----------

Section II (to be completed by requesting agency)

Reason for request	Behavioral Health Check <input type="checkbox"/>
	ASAP Check <input type="checkbox"/>
Name and Agency of Requestor	Grade
E-mail address	Signature

Section III (to be completed by Behavioral Health or ASAP)

Findings (derogatory information on record) No <input type="checkbox"/> Yes <input type="checkbox"/>	Brief Summary of results- further information may be requested if a Program Review Board is held.
--	---

This is to certify that the above data is correct and true according to the record on file in this office. This information is confidential and cannot be used in any other manner except for official purposes.

Printed name and title	Date (YYYYMMDD)	Signature
------------------------	-----------------	-----------

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SPONSOR

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one)	
	<input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input checked="" type="checkbox"/> BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE Baumholder Mental Health Clinic TO RELEASE MY PATIENT INFORMATION TO:

(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS (Street, City, State and ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)

<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input checked="" type="checkbox"/> OTHER (Specify) Background check
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION	<input type="checkbox"/> LEGAL	

8. INFORMATION TO BE RELEASED
Background check for Baumholder

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION DATE (YYYYMMDD)	<input type="checkbox"/> ACTION COMPLETED
--	--	---

SECTION III - RELEASE AUTHORIZATION

I understand that:

- a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
- b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
- d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT <i>(If applicable)</i> self	13. DATE (YYYYMMDD)
--	---	---------------------

SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

ADAPCP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION

For use of this form, see AR 600-85; the proponent agency is DCSPER.

SPONSOR

SECTION A - CONSENT

I, _____, this _____ day of _____ 19____,
(client's full name)

do hereby voluntarily consent to the release of the following information by USAG Baumholder ASAP
(name of installation ADAPCP)

pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with
alcohol or other drug abuse education, training, treatment, rehabilitatiton, or research to USAG Baumholder

_____ for the purpose of _____
completing a background check for _____

_____ namely,
whether enrolled in ASAP or if any history of positive urinalysis test

(extent or nature of information to be disclosed)

SECTION B - EXPIRATION/REVOCAION

(Check applicable paragraph)

1. [X] I understand that this consent automatically expires when the above disclosure action has been taken in
reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at
any time.

- Or -

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 6-9b(4)(b) and 6-10e(3), AR 600-85)

2. [] I understand that this consent automatically expires 60 days from today's date or when my present
criminal justice system status changes to _____

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my
participation in the ADAPCP, I cannot revoke this consent until there has been a formal and effective
termination or revocation of my release from such confinement, probation, or parole.

Table with 3 columns: SIGNATURE OF CLIENT, NAME OF WITNESS, SIGNATURE, DATE. Includes 'X' marks for client and witness.

SECTION C - APPROVAL AUTHORITY FOR RELEASE OF INFORMATION

NOTE: Other than the MEDCEN/MEDDAC Commander, approval authority for release of information may be delegated to the Program
Physician or the Clinical Director.

In my judgment, the release of an evaluation of the present or past status of _____
(client's name)
in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

Table with 2 columns: NAME OF MEDCEN/MEDDAC COMMANDER OR DESIGNATED REPRESENTATIVE, SIGNATURE, DATE.

DEPARTMENT OF THE ARMY
CHILD AND YOUTH SERVICES
UNIT 23746, BOX 18
APO, AE 09034

MEMORANDUM FOR: Family Housing, Unit Commander, School Counselor

SUBJECT: Request for Background Information and Investigation

1. The Individual below has applied for Family Child Care (FCC) certification to provide services as specified in AFR 608-10.

Sponsor's Name and Rank	DOB (MM/DD/YY)	SSN	Place of Birth	Work Phone#	Unit Address

Signature of Sponsor (to release Information)

_____ Date: _____

Applicant's Name	DOB (MM/DD/YY)	SSN	Place of Birth	Home Phone#	Home Address

Signature of Applicant (to release Information)

_____ Date: _____

Privacy Act Statement:

This Information will only be used to process applications, will remain confidential, and will not be released to other individuals or agencies and will only be used to monitor the CYS program.

Information requested by Hildegard Bragg, FCC Director, DSN 485-6588

Records reveal no derogatory information:

Records reveal derogatory information:

Agency/ Unit Commander Signature & Date

The last 3 pages are for you to keep.

They cover some of the requirements being an FCC provider and some things to think about when deciding to become an FCC provider.

Once I Am Certified

1. I must nurture and care for children with affection and respect.
2. I must identify and respond with appreciate care giving techniques to a child's emotional and physical needs.
3. I must interact directly with children in program activities as opposed to passive observation and monitoring.
4. I must role model communication and social interaction skills.
5. I must provide experiences that enhance children's self-concept.
6. I must acknowledge unique qualities in each child.
7. I must stimulate and foster the child's intellectual capabilities.
8. I must observe children in care for evidence of potential child abuse and neglect and will report to designated personnel.
9. I must use appropriate discipline techniques, not corporal punishment.
10. I must provide continuous, watchful supervision of children at all times.
11. I must remain on the premises when children are in the FCC home except in an emergency.
12. I must remain in close proximity to children during periods of activity.
13. I must be present during all times children are in the kitchen.
14. I must provide constant supervision when children under age 5 are in bathtub, shower, wading pool, playing with standing water, or using plumbing fixtures and appliances that have a temperature that exceeds 110 F.
15. I must observe napping children periodically.
16. I must not allow children under age 5 to play unsupervised in unfenced outdoor play areas.
17. I must not care for more children than authorized including my own.
18. I must monitor interior spaces and outside activity areas.
19. I must provide a contingency plan for the care of children.
20. I must maintain an operable telephone in my home.
21. I must attend a minimum 24 hours of training annually.
22. I must maintain my own training hours and re-inspection dates with minimal assistance from FCC staff.
23. I must be able to speak, read, and write English or the language of the host nation to the extent that I can execute health and safety directives and in order to implement English language development for children.
24. I must ensure my pets pose no threat to children.
25. I must be trained in evacuation procedures.
26. I must conduct and document fire drills at least once a month.
27. I must allow support agencies (e.g., CDS, FCC, Family Housing, Fire and Safety Officials, Provost Marshal, Preventive Medicine) into my home for inspections.
28. I must screen children for illness.
29. I must not administer medicine unless I have been properly trained and parental permission has been granted.
30. I must not use drugs or alcohol during child care hours or prior to child care when residual or permanent effects may continue into child care hours.
31. I must not smoke while in direct contact with children.
32. I must not hold another job during child care hours or conduct other business.
33. I must complete paperwork on each child in care as prescribed by my community (to include DA Forms 4719, 5222, 5223, 5224, 5225, 5226).
34. I must provide parents with a copy of our contract and submit each contract to review by FCC staff.
35. I must provide a two week written notice to parents prior to discontinuing my services.
36. I must report my availability status to the FCC office as changes occur.
37. I must display my FCC certificate and window poster.
38. I must return my certificate and window poster to the FCC office if suspended or revoked. I must also return any window poster before moving to another community.
39. I must maintain all requirements as specified in AR 608-10 and in my community child care regulations.

Things to Consider

Here are some things to think about.

	Yes	No
1 Are you healthy, physically and mentally?		
2 Are you calm and clear-headed in an emergency or crisis?		
3 Do you like children? Are you prepared to accommodate different personality types among those in your care – for example, shy and hesitant, or high-spirited and active?		
4 Are you willing to follow regulations that don't allow hitting, humiliating, frightening, or threatening children in your care?		
5 Are you financially able to purchase nutritional meals, arts and craft materials, and other equipment? (The FCC Toy Lending Resource Library and Subsidy Program help, but there are out-of-pocket costs.)		
6 Are you willing to attend training sessions that help you learn new ways of thinking about children and working with them?		
7 We all face personal and Family problems at one time or another, and working in your home may be a reminder of those problems. Can you put those troubles aside while caring for children?		
8 A Provider works long hours. Young children may be a challenge, and very active when your energy is low. Can you manage your stress and find the energy you need?		
9 Some parents have different lifestyles from yours. Many times, you may not agree with the way certain parents behave or how they're raising their children. Can you accept these parents for who they are without judging or trying to "fix" them?		
10 Can you care for children without wanting to "rescue" them from parents who are different than you?		
11 Sometimes parents are delayed by work – or just simply late in picking up their children. If this happens, can you juggle family responsibilities while still providing the same level of quality care?		
12 If your own child has "challenging" behaviors, bringing in play-mates may not solve the situation. In fact, it might be aggravated. So ask yourself – does your child have any behaviors that could affect or endanger the other children under your care?		
13 Parents depend on the FCC Provider to give their children quality care, and that's a full-time job. Do you understand that adult interaction may be limited? Can you agree not to go shopping or visiting during the day?		
14 When you need a Substitute Provider, will you be able to find one? The FCC staff will help make the arrangements, but it is your responsibility to locate a qualified substitute.		

