ORANGE COUNTY GOVERNMENT

Interoffice Memorandum

December 14, 2021

AGENDA ITEM

TO: Mayor Jerry L. Demings

-AND-

County Commissioners

THRU: Lonnie C. Bell, Jr., Director, Virgue

Community and Family Services Department

FROM: Sonya L. Hill, Manager

Head Start Division

Contact: Sandra Moore (407) 836-8913 Sonya Hill (407) 836-7409

SUBJECT: Consent Agenda Item – January 11, 2022

Florida Department of Children and Families

Applications for Licenses to Operate Child Care Facilities

The Head Start Division requests Board approval for renewal licenses between the Florida Department of Children and Families and Orange County. These licenses will allow the Head Start Program to provide comprehensive early childhood development for preschool children and support to their families at the following Head Start locations for the 2021-2022 school year. The licenses fees will be paid with Head Start funds.

Center Name	Expiration Date	Fee
1. Pine Hills Community Center Head Start	March 12, 2022	\$100
2. Hal P. Marston Head Start	March 16, 2022	\$100
3. Bithlo Head Start	March 24, 2022	\$60
4. East Orange	April 14, 2022	\$100
5. Southwood Head Start	April 30, 2022	\$100
6. John H. Bridges Head Start	May 07, 2022	\$100
7. Callahan Head Start	July 06, 2022	\$62

These are standard applications for licenses that are required by the Florida Department of Children and Families for licensed child care facilities.

Consent Agenda Item – January 11, 2022 Florida Department of Children and Families Applications for Renewal Licenses to Operate Child Care Facilities Page 2

ACTION REQUESTED: Approval and execution of Florida Department of

Children and Families Applications for a License to Operate a Child Care Facility at Pine Hills Community Center, Hal P. Marston, Bithlo, East Orange, Southwood, John H. Bridges, and Callahan Head

Start sites.

SLH/am:jamh

Attachments

c: Carla Bell Johnson, AICP, Assistant County Administrator Avis McWhite, Senior Program Manager, Head Start Division



1 BCC Mtg. Date: Jan. 11, 2022

APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRAM INFORMATION (this see	ction must be co	ompleted in it	s entirety)	
	enewal	Change	of R	evision of
(choose one): License Ye	ar:	Ownersh	ip Ex	xisting License
Name of Facility as it is to appear on license:		Telephone	Number Alternarea code:	nate Phone Number:
Pine Hills Community Center Head Start		(407)2		
Street Address of Facility (physical address):	City	Co	ounty	Zip Code:
6408 Jennings Road	Orlando		Orange	32818
Mailing Address of Facility, if different (include city and zip of				
2100 East Michigan Street Orlando FL 3280	06			
E-Mail Address:				cluding area code):
Sunitha.Koorathota@ocfl.net			(407)83	
	f yes, all household			
	packground screening of family members with the screen of the screen in the screen is a screen in the screen in the screen is a screen in the screen is a screen in the screen in the screen is a screen in the screen in the screen is a screen in the screen in the screen is a screen in the screen in the screen is a screen in the screen in the screen in the screen is a screen in the screen in th			055
Days and Hours of Operation – please check AM of			and dates of bil	U1.
24 Hour Care				
Mo n day Tuesday Wednesda	y Thursday	Friday	Saturday	Sunday
		✓ AM	I AM	AM
Opening	м 7:00	7:00 PM	PM	PM
AM DAM DAM	 NI	AM	AM	AM
Closing PM 6:00 PM 6:00 PM 6:00 PM		6:00 PM		PM
Time. 0.00 (F) W 0.00 (F) W 0.00 (F)	VI 0.00 [V] / IVI	0.00		
Months of Operation: School 12 Months Year Only	S Other:			
Program Designations:				
Faith Based Head Start Urban Zone	Public/Non-F	Public School	VPK So	chool Readiness
Check all service options that apply:				
Full Day Half Day Drop-In	Night Care Bef	ore School Aft	ter School W	/eekend
		\		
Infant Care (0-1) Food Served T	ransportation			



Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss, 402.305 and 402.308, F.S.

PART 2: OWNERSHIP TYPE (check	(one)					
Individual Ownership – Not incorporate	d Individual Ow	Individual Owner Cor				
Corporation	Corporation D	ocumentation required		Complete Sections B and F		
Limited Liability Company (LLC)	LLC Documer	ntation required		Complete Sections C and F		
Partnership – Not Incorporated	Partnership D	ocumentation required		Complete Sections D and F		
Other Entity – Not Incorporated		oard, Local Government, Before ams, Parks and Recreation, Faith		Complete Sections E and F		
SECTION A: INDIVIDUAL OWNERS	HID _ NOT INC	OPPOPATED (Special Instru	ctions	One owner)		
Name (First, Middle and/or Maiden, Last):	THE - NOT INC	ONFORATED (Special Illsuu	Cuons.	One Owner)		
rtame (i wat, image angre: margen, gaet).						
Date of Birth:		*Social Security number;		_		
		9				
Home Address:		City:	State:	Zip Code:		
2						
Telephone Number (including area code):						
SECTION B: CORPORATION (S Articles of Incorporation, which must in member of the Board of Directors. Also a Failure to continuously maintain a registe license. For RENEWAL applications for of Authorization from the Department of S	clude the names, ttach the name a red office and/or i child care licens	nd telephone number of the corp registered agent in Florida is grou ure, attach a current copy of Cert	phone nu oration's unds for r	umber for each registered agent. revocation of this		
Name of Corporation:		Corporate and FEIN #:				
Address of Corporation:		Incorporated in which State?				
		If out-of-state, is the corporation registered in the State of Florida? Yes No lf no, please register prior to submitting an application.				
City: State:	Zip Code: Telephone Number (including area code):					
		Data of Births	1 + 0 -	saial Caassiks Northan		
Designated Corporate Representative:		Date of Birth:	*50	ocial Security Number:		
Home Address:		City:	State:	Zip Code:		

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION C: LIMITED LIA licensure, attach Articles of number for each member of registered agent. Failure to for revocation of this license. Certificate of Status/Certificat Name of Company:	the Compa continuous For RENE	tion, which must i any. Also attach t sly maintain a regi EWAL application	include the nam istered is for ch	the names, the title/offine and telephone number office and/or registered wild care licensure, attach	ice, addres er of the co agent in F n a current	ss, and telephone orporation's Florida is grounds copy of
Address of Company:			Organi	zed in which State?		
Addition of company.			0.3	Edd III Willow Clare.		
			Y	es No submittir	ease register ng an applica	prior to
City:	State:	Zip Code:	Teleph	one Number (including area	a code):	
Designated Company Representat	tive:			Date of Birth:	*Soc	ial Security Number:
Home Address:			City:		State:	Zip Code:
SECTION D: PARTNERS Partnership Agreement annu Partner #1 (First, Middle (Maiden)	ually. Attac		ets as a	pplicable if more than tv		
Date of Birth:			*Socia	Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area	a code):					
Partner #2 (First, Middle (Maiden)	, Last):					
Date of Birth:			*Socia	Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area	code):					
SECTION E: OTHER ENT operated by School Boards of and other non-incorporated e Name of Entity: Orange County, Florida Entity's Designated Representative	or city/cour entities.)	nty mynicipalities,	before`			
Address of Entity (street address): 201 South Rosalind Aver			City:	ndo	State:	Zip Code: 32801
Telephone Number (including area (407)836-6590			0			02001

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION F: ON-SITE DIRECTOR INFO An On-site Director holds a Director Credenti to be on-site for the majority of operating hou multiple before-school and after-school programmber of children enrolled; or, (b) More than	al, is responsible for the day-to-day oper rs. A Multi-Site Director holds a Directo ams for a single organization as follows:	ration of the faci r Credential and (a) Three sites	ility and is required I supervises Is regardless of the
Name (First, Middle and/or Maiden, Last): Sunitha Koorathota			
Date of Birth:	*Social Security number:		
Home Address: 714 Westcliffe Drive	City: Winter Garden	State	Zip Code: 34787
Cell Phone Number (including area code): If applic (407)325-6875		Di .	
PART 3: ATTESTATION (To be completed)	eted by all applicants)		
Has the owner, applicant, or director ever had	d a license denied, revoked, or suspend		or jurisdiction, been
the subject of a disciplinary action, or been fir Yes No If yes, please expla	ned while employed in a child care facilit iin (attach additional sheet(s) if necessa	•	
I hereby attest that the information contained	in this section is truthful and correct und	ler penalty of pe	erjury Initial
Have you or anyone identified as a party to or with any state agency in any capacity other the Yes No If yes, where, what			
Pursuant to section 402.3054, F.S., child e upon screening, using level 2 standards in provider, it is the responsibility of the direct accordingly, and parents/guardians provide conducted by the child enrichment service	Chapter 435, F.S. If this facility utilize tor to ensure that the child enrichment written consent before a child may p	zes a child enr nt service prov	ichment service ider is screened
The Health Insurance Portability and Account information must be protected from disclosion the public and to otherwise assure the privativative agree to comply with the requiremental children's health records in your possession.	ure and maintained in a manner to pr acy of such information. Your signat ents of HIPAA by protecting the confi	event inadvert ure on this app	ent disclosure to dication indicates
In accordance with s. 402.319(3), F.S., each with the provisions of s. 39.201, F.S., regar Jerry L. Demings , Applicant do hereby affirm that all child care personn	rding the requirements of a mandated of Pine Hills Community Center Head	reporter. By Start Ch	signing below, !,
Pursuant to section 435.05(3), F.S., each em of Chapter 435, F.S., regarding the statutor Jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., each em of Chapter 435, F.S., regarding the statutor Jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., each em of Chapter 435, F.S., regarding the statutor jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., each em of Chapter 435, F.S., regarding the statutor jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry L. Demings , Applicant of attest under penalty of perjury that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry that all child cannot be a section 435.05(3), F.S., regarding the statutor jerry that all child cannot be a section 435.05(3), F.S., regarding the section 435.05(3), F.S., regarding the statutor jerry that all child cannot be a section 435.05(3), F.S., regarding the section 435.05(3), F.S., rega	ry requirements for background scree of Pine Hills Community Center Head	ening. By sign Star Child Care	ing below, I Facility, do hereby
Ryum. Bwohn Signature of Applicant	January 11, 2022 Date	_	

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information.

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law.

January 11, 2022 Date

Person completing application if other than Owner or Organization's Designated Representative. Name (please print): Title/Position/Relationship to the Owner: Telephone Number, including area code: Do Not Write Below this Line - Official Use Only Received by Signature/Initials: Date Fee Received: | Amount: Check Number: Date Fee Forwarded to Fiscal Office: Sexual Offender Address Cross-Reference Exact Address Match: Date of Search: Conducted by Signature/Initials: (http://offender.fdle.state.fl.us): Yes No



BCC Mtg. Date: Jan. 11, 2022 APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRAM INFORMATION (this section must be completed in its entirety)						
	enewal ar: 2022	Change of Ownership		Revision of Existing License		
Name of Facility as it is to appear on license: Hal P. Marston Head Start		Telephone N (including ar (407)83	rea code):	rnate Phone Number:		
Street Address of Facility (physical address):	City:	Cou	unty:	Zip Code: 32808		
3933 W. D. Judge Drive Mailing Address of Facility, if different (include city and zip			ORANGE	32000		
2100 EAST MICHIGAN STREET ORLAND E-Mail Address:	OO, FL 32806		FAX Number (i	including area code):		
Tiffany.Brown@ocfl.net			(407)8	36-8440		
adjacent to the home of the Yes No	If yes, all household men background screening co of family members with t	ompleted. P	lease attach	a list Capacity:		
Days and Hours of Operation – please check AM 24 Hour Care	or PM as applicable:	-				
Opening = = = = = = = = = = = = = = = = = =	ay Thursday AM ☑AM PM 7:30 □ PM 7:3	Friday AM PM	Saturday AM			
Closing	AM ☐ AM PM 5:300 PM 5:3	AM PM	AM			
Months of Operation: School 12 Months Other:						
Program Designations: Faith Based Head Start Urban Zon	e Public/Non-Public	c School [VPK	School Readiness		
Check all service options that apply:		0 1 1 40	0 1 1			
Full Day Half Day Drop-In	Night Care Before	School Afte	er School	Weekend		
Infant Care (0-1) Food Served ✓	Transportation					



PART 2: OWNERSHIP TYPE (check	one)					
Individual Ownership – Not incorporated	Individual Ow	/ner				omplete Sections and F
Corporation	Corporation [Corporation Documentation required				omplete Sections and F
Limited Liability Company (LLC)	LLC Docume	ntation r	equired			omplete Sections and F
Partnership – Not Incorporated	Partnership [Documer	ntation required			omplete Sections and F
Other Entity – Not Incorporated			ocal Government, Before ks and Recreation, Faith			omplete Sections and F
SECTION A: INDIVIDUAL OWNERS Name (First, Middle and/or Maiden, Last):	HIP – NOT INC	CORPO	RATED (Special Instru	uction	s: Or	ne owner)
Date of Birth:		*Socia	Security number:			
Home Address:		City: State:				Zip Code:
SECTION B: CORPORATION (Sp. Articles of Incorporation, which must income member of the Board of Directors. Also a Failure to continuously maintain a register license. For RENEWAL applications for	clude the names ttach the name a ed office and/or	, the title and telep registere	phone number of the corp ed agent in Florida is gro	ephone poratio unds f	num n's re or rev	ber for each gistered agent. ocation of this
of Authorization from the Department of S		rough S	unBiz.org).			
Name of Corporation:		Corpor	ate and FEIN #:			
Address of Corporation:		Incorpo	orated in which State?			
			of-state, is the corporation r	ase reg	gister p	orior to
City: State:	Zip Code:	Teleph	one Number (including area	code):		
Designated Corporate Representative:			Date of Birth:		*Socia	al Security Number:
Home Address:		City:		State	:	Zip Code:

licensure, attach Articl number for each memb registered agent. Failu for revocation of this lice Certificate of Status/Cer	les of Organiz per of the Comp ure to continuou ense. For REN	ation, which mu pany. Also attac usly maintain a r EWAL applicati	(Special Instructions: Uponst include the names, the tire of the name and telephone registered office and/or registions for child care licensure, the Department of State (available).	tle/office, addre number of the o stered agent in attach a curren	ss, and telephone corporation's Florida is grounds t copy of
Name of Company:			Company and FEIN #:		
Address of Company:			Organized in which State?		
			Yes No si	no, please registe ubmitting an applic	r prior to
City:	State:	Zip Code:	Telephone Number (includi	ng area code):	
Designated Company Repre	esentative:		Date of Birth:	*So	cial Security Number:
Home Address:			City:	State:	Zip Code:
SECTION D: PARTN Partnership Agreement Partner #1 (First, Middle (M	t annually. Atta	OT INCORPOR ach additional sh	ATED (Special Instruction neets as applicable if more to	ons: Attach a c	opy of the
Date of Birth:			*Social Security number:		
Home Address (street addre	ess):		City:	State:	Zip Code:
Telephone Number (includir	ng area code):				
Partner #2 (First, Middle (M.	aiden), Last):				*10
Date of Birth:			*Social Security number:		
Home Address (street addre	ess):		City:	State:	Zip Code:
Telephone Number (includin	ng area code):				
	rards or city/courated entities.) /, FLORIDA	unty municipalition	CATED (Special Instructions) es, before and after school h, Last):		
Address of Entity (street address of Entity	LIND AVENU	JE	City: ORLANDO	State:	Zip Code: 32801

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION F: ON-SITE DIRECTO An On-site Director holds a Director of to be on-site for the majority of opera multiple before-school and after-school number of children enrolled; or, (b) M	Credential, is responsi iting hours. A Multi-Sit ool programs for a sing	ble for the day-to-d te Director holds a lle organization as	ay operation of Director Cred follows: (a) T	of the faci ential and hree sites	lity and is required supervises regardless of the
Name (First, Middle and/or Maiden, Last): Tiffany Price-Brown					
Date of Birth:		*Social Security nur	mber:		
Home Address: 15351 Whitetail Loop	+	City: Mascotte		State:	Zip Code: 34753
Cell Phone Number (including area code): (407)467-7666	If applicable, name of N	Multi-Site Programs ar	nd enrollment:		
PART 3: ATTESTATION (To be	completed by all a	nnlicants)			
Has the owner, applicant, or director	ever had a license der	nied, revoked, or su		ny state o	or jurisdiction, been
the subject of a disciplinary action, or Yes No If yes, plea	ise explain (attach add		-		
I hereby attest that the information co	ontained in this section	is truthful and corr	ect under pen	alty of pe	
Have you or anyone identified as a pa			ld care, foster	care, cos	Initial smetology, etc.)
with any state agency in any capacity Yes No If yes, when Facility Certificate of License	re, what type of license	e, license number,			
Pursuant to section 402.3054, F.S., upon screening, using level 2 standprovider, it is the responsibility of the accordingly, and parents/guardians conducted by the child enrichment standard.	ards in Chapter 435, ne director to ensure provide written cons	F.S. If this facili that the child enr	ty utilizes a d ichment serv	child enri ice provi	chment service der is screened
The Health Insurance Portability an information must be protected from the public and to otherwise assure that you agree to comply with the rechildren's health records in your post	disclosure and main the privacy of such in equirements of HIPA	tained in a manne formation. Your	er to prevent signature on	inadvert this app	ent disclosure to lication indicates
In accordance with s. 402.319(3), F with the provisions of s. 39.201, F.S Jerry L. Demings , Ap do hereby affirm that all child care p	S., regarding the requipplicant of Hal P. Ma	uirements of a ma rston Head Start	indated repoi	ter. By	
Pursuant to section 435.05(3), F.S., of Chapter 435, F.S., regarding the Jerry L. Demings, Appattest under penalty of perjury that all	statutory requirement plicant of Hal P. Mars	nts for background ston Head Start	d screening. Cl	By sign	ing below, I Facility, do hereby
Rywww. Bwor	A STATE OF THE PARTY OF THE PAR	January 1	1, 2022		

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information.

2 Ducks

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law.

Signature of Owner or Organization's Designated Representative	January 11, 2022 Date	
		ENTER COUNTY FULL
Person completing application if other than Owner or Organization's I	Designated Represe	entative.
Name (please print):		
Title/Position/Relationship to the Owner:		
Telephone Number, including area code:		
÷		
Do Not Write Below this Line – Officia	al Use Only	
Date Fee Received: Amount: Check Number: Received by Sign	Date	Fee Forwarded to Fiscal Office:
Sexual Offender Address Cross-Reference Date of Search: Conducted	by Signature/Initials:	Exact Address Match:
(http://offender.fdle.state.fl.us):		Yes No

COMINITY COM

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

MYFLFAMILIES.COM

BCC Mtg. Date: Jan. 11, 2022 APPLICATION FOR A LICENSE
TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRAM	INFORMATIO	N (this se	ction must be con	npleted in	its entirety)		
Application Type [Initial	*Renewal			Change of		Revision of	
(choose one):	License	Ye	ear: 2022	Owner	ship	Existi	ng License	
Name of Facility as it is to a	ppear on license:				ne Number	Alternate P	hone Number:	
Bithlo Head Start)254-1928			
Street Address of Facility (p			City:		County:		Code:	
18501 Washington	Avenue		ORLANDO		ORANG	SE 32	2820	
Mailing Address of Facility, i								
2100 EAST MICHIG	SAN STREET	ORLAND	O, FL 32806					
E-Mail Address:			1			•	ng area code):	
Teri.Watts@ocfl.net					(40)	7)836-29	982	
Is this facility located in o			f yes , all household r				Maximum Capacity:	
adjacent to the home of t owner/operator?	he Yes		packground screening of family members with				60	
Days and Hours of Ope	ration – please				ioo ana datoo	Of Birdi.		
24 Hour Care							'	
Monday	Tuesday	Wednesda	ay Thursday	Friday	Saturd	ay	Sunday	
MAM	AM		M AM	✓ A		AM	AM	
Opening Time: 7:00 PM	7:00 PM 7	7:00 P	м <u>7:00</u> Рм <u>7</u>	7:00 P	м	РМ	PM	
ПАМ	MAM	Па	M AM	Па	м	AM	ПАМ	
Closing Time: 6:00 PM	6:00 ₽PM 6	6:00 ₽	м <u>6:00</u> РМ <u>6</u>	6:00	м	РМ	PM	
Months of Operation: School 12 Months Other:								
Program Designations:								
Faith Based	lead Start 🔲	Jrban Zone	Public/Non-Pu	ıblic School	VPK	School	l Readiness	
Check all service option							_	
Full Day	Half Day [Orop-In	Night Care Befor	re School	After School	Week	end]	
Infant Care (0-1) Food Se	erved	Transportation					
							7 Pull (F)	



PART 2: OWNERSHIP TYPE (check	one)				
Individual Ownership – Not incorporated	Individual Owr	ner	25.3	Complete Sections A and F	
Corporation	Corporation D	Corporation Documentation required			
Limited Liability Company (LLC)	LLC Documen	ntation required		Complete Sections C and F	
Partnership – Not Incorporated	Partnership Do	ocumentation required		Complete Sections D and F	
Other Entity – Not Incorporated		oard, Local Government, Befor ms, Parks and Recreation, Fair		Complete Sections E and F	
SECTION A: INDIVIDUAL OWNERSH	IIP – NOT INC	ORPORATED (Special Inst	ructions:	One owner)	
Name (First, Middle and/or Maiden, Last):					
Date of Birth:		*Social Security number:			
Home Address:	ŭ	City:	State:	Zip Code:	
Articles of Incorporation, which must include member of the Board of Directors. Also atta	ude the names, ach the name ar	nd telephone number of the co	elephone reporation's	number for each s registered agent.	
Failure to continuously maintain a registere license. For RENEWAL applications for of Authorization from the Department of Sta	hild care licensu	ure, attach a current copy of Crough SunBiz.org).			
Name of Corporation:		Corporate and FEIN #:			
Address of Corporation:		Incorporated in which State?			
		If out-of-state, is the corporation registered in the State of Florida? Yes No lf no, please register prior to submitting an application.			
City: State: Z	ip Code:	Telephone Number (including ar	ea code):		
Designated Corporate Representative:	,	Date of Birth:	*S	ocial Security Number:	
Home Address:		City:	State:	Zip Code:	

SECTION C: LIMITED LIA licensure, attach Articles of number for each member of registered agent. Failure to for revocation of this license. Certificate of Status/Certificat Name of Company:	Organiza the Compa continuous For RENE	tion, which must i any. Also attach t sly maintain a regi EWAL application	nclude the name stered of	e and telephone numb office and/or registered ld care licensure, attact	ice, addre er of the o agent in a curren	ss, and telephone corporation's Florida is grounds t copy of
Address of Company:			Organiz	ed in which State?		
			Y	es No submittir	ease registe ng an appli	er prior to
City:	State:	Zip Code:	relepho	one Number (including area	a code):	
Designated Company Representat	live:	2		Date of Birth;	*Sc	ocial Security Number:
Home Address:			City:		State:	Zip Code:
SECTION D: PARTNERS Partnership Agreement annu Partner #1 (First, Middle (Maiden)	ually. Atta		ts as ap			
Date of Birth:			*Social	Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area						
Date of Birth:			*Social	Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area	code):					
SECTION E: OTHER ENT operated by School Boards of and other non-incorporated of Name of Entity: ORANGE COUNTY, FLO Entity's Designated Representative	or city/courentities.) ORIDA	nty municipalities,	before a			
Address of Entity (street address):			City:		State:	Zip Code:
201 SOUTH ROSALIND	AVENU	E	ORL	ANDO	FL	32801
Telephone Number (including area (407)836-6590	code):					,

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

An On-site Director holds a Director (to be on-site for the majority of opera multiple before-school and after-scho number of children enrolled; or, (b) M	Credential, is responsi ting hours. A Multi-Sit ool programs for a sing	ble for the day-to-da e Director holds a D le organization as fo	y operation of irector Crede ollows: (a) The	of the faci ential and nree sites	ity and is required supervises regardless of the			
Name (First, Middle and/or Maiden, Last): Teri Watts								
Date of Birth:		*Social Security num	ber:					
Home Address:	7.	City: State: Zip Code:						
427 Hemlook Lane		Titusville		FL	32780			
Cell Phone Number (including area code): (407)383-5962	If applicable, name of N	Multi-Site Programs and	d enrollment:					
PART 3: ATTESTATION (To be	completed by all a	pplicants)						
Has the owner, applicant, or director the subject of a disciplinary action, or	ever had a license de	nied, revoked, or sus loyed in a child care	facility?	ny state o	r jurisdiction, been			
I hereby attest that the information contained in this section is truthful and correct under penalty of perjury.								
Have you or anyone identified as a pawith any state agency in any capacity Yes No If yes, when Facility Certificate of License	other than a driver's re, what type of license	license? e, license number, a	nd under wha					
Pursuant to section 402.3054, F.S., upon screening, using level 2 stand provider, it is the responsibility of thaccordingly, and parents/guardians conducted by the child enrichment s	ards in Chapter 435, le director to ensure provide written cons	F.S. If this facility that the child enrice	y utilizes a c chment serv	hild enri	chment service der is screened			
The Health Insurance Portability and information must be protected from the public and to otherwise assure that you agree to comply with the rechildren's health records in your post	disclosure and main the privacy of such in equirements of HIPA.	tained in a manner formation. Your s	to prevent ignature on	inadverte this app	ent disclosure to lication indicates			
In accordance with s. 402.319(3), F with the provisions of s. 39.201, F.S Jerry L. Demings , Ap do hereby affirm that all child care p	S., regarding the requoplicant of Bithlo Hea	uirements of a man	dated repor	ter. By				
Pursuant to section 435.05(3), F.S., of Chapter 435, F.S., regarding the Jerry L. Demings , Appattest under penalty of perjury that all	statutory requiremen	nts for background	screening.	By signi	ng below, I			
Rywww. Bwok		January 11,	2022					

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information.

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law.

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Falsification of application information.

Falsification of application information.

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Do Not Write Below this Line - Official Use Only

Date Fee Received:	Amount;	Check Number:	Received by Signature/Initials:	Date Fee Forwarded to Fish	cal Office:
Sexual Offender Add (http://offender.fdle.s	lress Cross-Reference state.fl.us):	Date of Search:	Conducted by Signature/In	itials: Exact Address Mat	



BCC Mtg. Date: Jan. 11, 2022APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRAM INFORMATION (this s	section must be co	mnleted in	its entirety)			
	Renewal		Revision of			
(choose one): License Year: Ownership Existing Li						
Name of Facility as it is to appear on license:			ne Number Altengarea code):	rnate Phone Number:		
East Orange Head Start		(407))254-9713			
Street Address of Facility (physical address):	City:		County:	Zip Code:		
12050 East Colonial Drive	Orlando		Orange	32826		
Mailing Address of Facility, if different (include city and z						
2100 East Michigan Street Orlando FL 32	2806					
E-Mail Address:				ncluding area code):		
Yira.Rodriguez@ocfl.net			(407)83	36-2987		
Is this facility located in or	If yes, all household					
adjacent to the home of the Yes No owner/operator?	background screening of family members v					
Days and Hours of Operation – please check A			ies and dates of b	11 (1),		
24 Hour Care						
Monday Tuesday Wednes	day Thursday	Friday	Saturday	Sunday		
	AM AM	r riday ✓ Ar				
Opening = =						
Time: 7:30 PM 7:30 PM 7:30	PM 7:30 PM	7:30 P	MPM	PM		
Closing AM AM	AM AM	AI	MA AM	AM		
Time: 5:30 PM 5:30 PM 5:30	PM 5:30 ✓ PM	5:30 P	м ПРМ	ПРМ		
Months of Operation: School 12 Mon Year Only	ths Other:		_			
Program Designations:						
Faith Based Head Start Urban Zo	ne Public/Non-P	ublic School	VPK S	School Readiness		
Check all service options that apply:				3		
Full Day Half Day Drop-In	Night Care Befo	ore School	After School	Weekend		
Infant Care (0-1) Food Served	Transportation					



PART 2: OWNERSHIP TYP	PE (check	one)						
Individual Ownership – Not in	ncorporated	Individual Ow	ner				Complete Sections A and F	
Corporation		Corporation D	Documer	ntation required			Complete Sections B and F	
Limited Liability Company (L	LC)	LLC Docume	ntation r	equired			Complete Sections C and F	
Partnership – Not Incorporat	red	Partnership D	ocumer	ntation required			Complete Sections D and F	
Other Entity – Not Incorporate	ted		e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based					
SECTION A: INDIVIDUAL (OWNERSH	IIP – NOT INC	CORPO	RATED (Spec	ial Instru	ictions:	One owner)	
Name (First, Middle and/or Maiden, I			, o i u o	1011 LD (Open			One owner)	
Date of Birth:		*Social	Security number	;				
Home Address:			City: S		State:	Zip Code:		
Telephone Number (including area c	ode):							
SECTION B: CORPORATION Articles of Incorporation, which member of the Board of Director Failure to continuously maintain license. For RENEWAL application of Authorization from the Depart	ch must inclurs. Also atta a registered ations for ch	ide the names, ich the name ai d office and/or t nild care licensu	the title, nd telep registere ure, atta rough Si	office, address, hone number of agent in Florich a current copunBiz.org).	, and telept the corp da is grou	phone nu oration's unds for r	registered agent. revocation of this	
Name of Corporation:			Corporate and FEIN #:					
Address of Corporation:			Incorporated in which State?					
				If out-of-state, is the corporation registered in the State of Florida? If no, please register prior to submitting an application.				
City: S	tate: Zij	Code:	Telepho	ne Number (inclu	ding area	code):		
Designated Corporate Representative	e:			Date of Birth:		*So	cial Security Number:	
Home Address:			City:			State:	Zip Code:	

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION C: LIMITED licensure, attach Article number for each member registered agent. Failure for revocation of this licentificate of Status/Certi	es of Organiza er of the Compa re to continuous ense. For RENI	ation, which must bany. Also attach sly maintain a re EWAL application	st include the house a gistered off ons for child a Department	e names, the title/o and telephone num ice and/or registere care licensure, atta of State (available	office, addre	ess, and telephone corporation's Florida is grounds at copy of
Name of Company:				and FEIN #:		
Address of Company:			Organized	d in which State?	6	
			Yes	NO submit	please registe tting an applic	er prior to
City:	State:	Zip Code:	Telephone	e Number (including ar	ea code):	
Designated Company Repres	entative:		D	ate of Birth:	*\$0	ocial Security Number:
Home Address:			City:		State:	Zip Code:
SECTION D: PARTNE Partnership Agreement a Partner #1 (First, Middle (Main	annually. Atta			ecial Instructions: licable if more than	Attach a c two partne	opy of the rs.)
Date of Birth:			*Social Se	ecurity number:		
Home Address (street address	(s):		City:		State:	Zip Code:
Telephone Number (including	area code):					
Partner #2 (First, Middle (Maid	iden), Last):					
Date of Birth:			*Social Se	ecurity number:		
Home Address (street address	s):		City:	17.	State;	Zip Code:
Telephone Number (including	area code):					
SECTION E: OTHER E operated by School Boar and other non-incorporat Name of Entity: Orange County, Floric Entity's Designated Represent	rds or city/cour ted entities.) ida	nty municipalities	s, before an	ecial Instructions: d after school progi	These are	programs -based programs
Address of Entity (street addre			City:		State:	Zip Code:
201 South Rosalind A Telephone Number (including			Orland	0	FL	32801
(407)836-6590	area Gode,					

SECTION F: ON-SITE DIRECTO An On-site Director holds a Director Co to be on-site for the majority of operat multiple before-school and after-scho number of children enrolled; or, (b) Mo Name (First, Middle and/or Maiden, Last): Yira Rodriguez	Credential, is respons ting hours. A Multi-Si ol programs for a sing	ible for the day-to-o te Director holds a gle organization as	day operation Director Cred follows: (a) T	of the faci ential and hree sites	lity and is required supervises regardless of the
Date of Birth:		*Social Security nu	mber:		
Home Address:		City:		State:	Zip Code:
1225 Roma Court		Orlando		FL	32825
Cell Phone Number (including area code): (407)489-4261	If applicable, name of I	Multi-Site Prog ra ms a	nd enrollment:		
PART 3: ATTESTATION (To be	completed by all a	pplicants)			
Has the owner, applicant, or director ethe subject of a disciplinary action, or Yes No If yes, pleas I hereby attest that the information cor	been fined while emp se explain (attach add	oloyed in a child car	re facility? ecessary):		jury
					Initial
Have you or anyone identified as a pa with any state agency in any capacity Yes No If yes, where	-	icense?			metology, etc.)
Pursuant to section 402.3054, F.S., oupon screening, using level 2 standa provider, it is the responsibility of the accordingly, and parents/guardians proportions by the child enrichment seconducted enrichment secondu	rds in Chapter 435, e director to ensure provide written cons	F.S. If this facili that the child enri	ty utilizes a c chment servi	hild enric ce provid	hment service er is screened
The Health Insurance Portability and information must be protected from dother public and to otherwise assure the chat you agree to comply with the records in your possibilities.	lisclosure and main ne privacy of such ir quirements of HIPA	tained in a manne formation. Your	r to prevent i signature on	nadverte this appli	nt disclosure to cation indicates
n accordance with s. 402.319(3), F.S. with the provisions of s. 39.201, F.S. lerry L. Demings, App do hereby affirm that all child care pe	, regarding the requ plicant of East Oran	irements of a mage Head Start	ndated report	er. By s	
Pursuant to section 435.05(3), F.S., ea of Chapter 435, F.S., regarding the s lerry L. Demings, Appl attest under penalty of perjury that all o	tatutory requirement licant of East Orange	ts for background Head Start	screening. Chi	By signin Id Care F	g below, I acility, do hereby
Rumul RIVE					

Signature of Applicant

Signature of Applicant

Date

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information.

Owner or Organization's Designated Representative

Check Number.

Date of Search:

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law.

January 11, 2022

Date

Name (please print):	ation if other than Owner or		
Title/Position/Relatio	nship to the Owner:		
Telephone Number, i	ncluding area code:		

Received by Signature/InItlals:

Conducted by Signature/Initials:

Date Fee Received: | Amount:

(http://offender.fdle.state.fl,us):

Sexual Offender Address Cross-Reference

Date Fee Ferwarded to Fiscal Office:

Exact Address Match:

Yes



COMMISSIONERS

BCC Mtg. Date: Jan. 11, 2022APPLICATION FOR A LICENSE

TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRAM INFORMATION (this s	ection must be compl	leted in its	entirety)				
	Renewal	Change of Ownership		evision of isting License			
Name of Facility as it is to appear on license: SOUTHWOOD HEAD START Telephone Number (including area code): (407)254-6788							
Street Address of Facility (physical address): 6225 BROOKGREEN AVENUE	ORLANDO County: Zip Code: 32809						
Mailing Address of Facility, if different (include city and zing 2100 EAST MICHIGAN STREET ORLAN)							
E-Mail Address: VIVIAN.JONES@ocfl.net			(407)836				
Is this facility located in or adjacent to the home of the Yes No owner/operator?	If yes , all household mer background screening co of family members with t	ompleted. Pl	ease attach a li	ist Capacity:			
Days and Hours of Operation – please check AN	I or PM as applicable:						
Opening = = =	day Thursday AM	Friday AM PM	Saturday AM PM	Sunday AM PM			
Closing = =	AM	□ AM 0 ☑ PM	AM PM	AM PM			
Months of Operation: School 12 Months Year Only	ths Other:						
Program Designations: ☐ Faith Based	ne Public/Non-Public	c School	VPK Sc	chool Readiness			
Check all service options that apply: Full Day Half Day Drop-In	Night Care Before	School Afte	r School W	eekend			
Infant Care (0-1) Food Served	Transportation						



PART 2: OWNERSHIP TYPE (check of	one)					
Individual Ownership – Not incorporated	Individual Ov	/ner			Com A an	plete Sections d F
Corporation	Corporation I	Corporation Documentation required				
Limited Liability Company (LLC)	LLC Docume	LC Documentation required				
Partnership – Not Incorporated	Partnership [Partnership Documentation required				
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based					plete Sections d F
SECTION A: INDIVIDUAL OWNERSH Name (First, Middle and/or Maiden, Last): Date of Birth:	IIP – NOT IN		PRATED (Special Inst	ruction	s: One	owner)
Home Address:		City: State:				p Code:
SECTION B: CORPORATION (Spe Articles of Incorporation, which must inclu- member of the Board of Directors. Also atta Failure to continuously maintain a registered license. For RENEWAL applications for cl	ude the names ach the name a d office and/or	, the title and telep register	phone number of the co ed agent in Florida is gr	lephone rporatio ounds f	number n's regis or revoca	r for each stered agent. ation of this
of Authorization from the Department of Sta		rough S	unBiz.org).			
Name of Corporation:		Corpor	ate and FEIN #:			
Address of Corporation:		Incorp	orated in which State?			
				lease reg	ed in the S gister prio oplication	or to
City: State: Z	ip Code:	Teleph	one Number (including are	ea code)		
Designated Corporate Representative:			Date of Birth:		*Social S	Security Number
Home Address:		City:		State	: Zi	p Code:

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION C: LIMITED LIA licensure, attach Articles of number for each member of registered agent. Failure to for revocation of this license. Certificate of Status/Certificat	Organiza the Comp continuou For REN	ation, which must any. Also attach t sly maintain a reg EWAL application	include the nar the name and t istered office a s for child care epartment of S	nes, the title/offi elephone numbe nd/or registered licensure, attach tate (available th	ce, addreser of the cagent in I	ss, and telephone orporation's Florida is grounds copy of	
Name of Company:			Company and F	FEIN #:			
Address of Company:			Organized in w	hich State?			
			If out-of-state, is the company registered in the State of Florida? Yes No submitting an application.				
City:	State:	Zip Code:	Telephone Number (including area code):				
Designated Company Representa	tive:		Date of	Birth:	*Soc	cial Security Number:	
Home Address:			City:		State:	Zip Code:	
SECTION D: PARTNERS Partnership Agreement annu Partner #1 (First, Middle (Maiden)	ually. Atta						
Date of Birth: *Social Security number:							
Home Address (street address):			City:		State:	Zip Code:	
Telephone Number (including area	a code):				4	*	
Partner #2 (First, Middle (Maiden)	, Last):						
Date of Birth:			*Social Security	y number:			
Home Address (street address):			City:		State:	Zip Code:	
Telephone Number (including area	a code):						
SECTION E: OTHER ENT operated by School Boards and other non-incorporated	or city/cou						
Name of Entity: ORANGE COUNTY, FL							
Entity's Designated Representativ		ldle and/or Maiden, L	ast):		*		
Address of Entity (street address) 201 SOUTH ROSALING Telephone Number (including area	AVENU	E	City:)	State:	Zip Code: 32801	
(407)836-6590	a coue).						

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION F: ON-SITE DIRECTO An On-site Director holds a Director Of to be on-site for the majority of operat multiple before-school and after-school number of children enrolled; or, (b) M	Credential, is responsil ting hours. A Multi-Sit ol programs for a sing	ole for the day-to-day e Director holds a Director le organization as follo	operation of ector Creder ows: (a) The	the facilit ntial and s ree sites r	ty and is required supervises regardless of the
Name (First, Middle and/or Maiden, Last): Vivian Jones					
Date of Birth:		*Social Security number	er:		
Home Address: 420 Eaton Street		City: Orlando	S	State: FL	Zip Code: 32751
Cell Phone Number (including area code): (407)923-7750	If applicable, name of N	lulti-Site Programs and e	enrollment:		
PART 3: ATTESTATION (To be	completed by all a	pplicants)			
Has the owner, applicant, or director of the subject of a disciplinary action, or Yes No If yes, please		loyed in a child care fa	acility?	y state or	jurisdiction, been
I hereby attest that the information co	ntained in this section	is truthful and correct	under pena	ılty of perj	ury
Have you or anyone identified as a pay with any state agency in any capacity Yes No If yes, where Facility Certificate of License	other than a driver's I re, what type of license	icense? e, license number, and	d under what		netology, etc.)
Pursuant to section 402.3054, F.S., upon screening, using level 2 stands provider, it is the responsibility of th accordingly, and parents/guardians conducted by the child enrichment s	ards in Chapter 435, e director to ensure provide written cons	F.S. If this facility that the child enrich	utilizes a ch ment servic	nild enricl ce provide	hment service er is screened
The Health Insurance Portability and information must be protected from the public and to otherwise assure t that you agree to comply with the rechildren's health records in your post	disclosure and main he privacy of such ir quirements of HIPA	tained in a manner to formation. Your sign	o prevent ir nature on t	nadverter this appli	nt disclosure to cation indicates
In accordance with s. 402.319(3), F. with the provisions of s. 39.201, F.S Jerry L. Demings , Ap do hereby affirm that all child care p	., regarding the requ oplicant of Southwoo	irements of a mand d Head Start	ated report	er. By si	
Pursuant to section 435.05(3), F.S., e of Chapter 435, F.S., regarding the Jerry L. Demings , App attest under penalty of perjury that all	statutory requirement	its for background s Head Start	creening. I Chi	By signin Id Care F	g below, I acility, do hereby
Bywww. Bwo Signature of Applicant	A CONTRACTOR	January 11, 202.	2		

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information.

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law.

Signature of Owner of	W. Bu or Organization	's Designated Repre	esentative	January 11, Date	2022	TOWN TOWN TOWN
Person completing applie Name (please print)	cation if other	er than Owner or	Organization's Do	esignated Re	presentati	ve.
Title/Position/Relation	onship to the C)wner:				
Telephone Number,	including area	code:				
				2		
	¥				9	
	Do I	Not Write Below t	this Line – Officia	l Use Only		·
Date Fee Received; Amount	i:	Check Number:	Received by Signa	ture/Initials:	Date Fee Fo	orwarded to Fiscal Office
Sexual Offender Address Cro http://offender.fdle.state.fl.us		Date of Search:	Conducted by	/ Signature/Initia	als: Exa	ct Address Match:

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

MYFLFAMILIES.COM

CC Mtg. Date: Jan. 11, 2022 APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRA	M INFORMATIO	ON (this se	ction must be co	ompleted in	its entirety)		
Application Type (choose one):	☐ Initial License		enewal ear: 2022				sion of ng License
Name of Facility as it is t John H. Bridges I	Head Start			(includi	ne Number ng area code):)254-9421	Alternate F	Phone Number:
Street Address of Facility 445 West 13th St	reet		City: Apopka		County: ORANGE		Code: 2803
Mailing Address of Facili 2100 EAST MICH							
E-Mail Address: Wilna.Francois@	ocfl.net				(407)836-1	ng area code): 934
							Maximum Capacity: 166
Days and Hours of C 24 Hour Care Monday Opening Time: 7:30 PN Closing Time: 5:30 PN Months of Operation Program Designation Faith Based Check all service op Full Day	Tuesday AM 7:30 PM AM 5:30 PM 5:30 PM School Year Only The ad Start Tuesday AM The A	Wednesda 7:30 F	Thursday AM PM 7:30 PM AM AM S:30 PM Other: Public/Non-	Friday A 7:30 P	MF MF MF	AM	Sunday AM PM AM PM OI Readiness
Infant Car	re (0-1) Food S	Served	Transportation		121		



PART 2: OWNERSHIP TYPE (check of	one)					
☐ Individual Ownership – Not incorporated	Individual Owr	ner	Complete Sections A and F			
Corporation	Corporation D	ocumentation required	Complete Sections B and F			
Limited Liability Company (LLC)	LLC Documen	ntation required	Complete Sections C and F			
Partnership - Not Incorporated	Partnership De	ocumentation required	Complete Sections D and F			
Other Entity – Not Incorporated		oard, Local Government, Before & ms, Parks and Recreation, Faith E				
SECTION A: INDIVIDUAL OWNERSH Name (First, Middle and/or Maiden, Last):	IP – NOT INC	ORPORATED (Special Instruc	ctions: One owner)			
Date of Birth:		*Social Security number:				
Home Address:		City:	State: Zip Code:			
Articles of Incorporation, which must inclumember of the Board of Directors. Also atta Failure to continuously maintain a registered license. For RENEWAL applications for continuously maintain a registered license.	ude the names, ach the name and d office and/or r hild care licensu	nd telephone number of the corpo egistered agent in Florida is grou ure, attach a current copy of Certi	phone number for each pration's registered agent. nds for revocation of this			
of Authorization from the Department of Sta Name of Corporation:	te (available thi	Corporate and FEIN #:				
Address of Corporation:	,	Incorporated in which State? If out-of-state, is the corporation registered in the State of Florida? If no, please register prior to submitting an application				
City: State: Z	ip Code:	Telephone Number (including area	an application. code):			
Designated Corporate Representative:		Date of Birth:	*Social Security Number:			
Home Address:](q 	City:	State: Zip Code:			

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

			Special Instructions: Upo				
			include the names, the tit				
			gistered office and/or regis				
			ns for child care licensure,				
Certificate of Status/Certificate	icate of Author	orization from the I	Department of State (availa	ble through Sur	nBiz.org).		
Name of Company:			Company and FEIN #:				
Address of Company:			Organized in which State?				
			If out-of-state, is the compa	inv registered in the	ne State of Florida?		
				no, please registe			
		- 20		ubmitting an applic	cation.		
City:	State:	Zip Code:	Telephone Number (including	ng area code):			
Designated Company Represe	entative:		Date of Birth:	*So	cial Security Number:		
Home Address:			City:	State:	Zip Code:		
Treme riddress.							
AFATION DA DANTAG	DOLUB AL	OT INCORPORA	TED (0 111 1 11				
SECTION D: PARTNE							
Partnership Agreement a		ach additional she	ets as applicable if more t	nan two partne	rs.)		
raither #1 (First, Middle (Maid	ieii), Last).						
Date of Birth:			*Social Security number:				
Home Address (street address	s):		City:	State:	Zip Code:		
		4					
Telephone Number (including	area code):						
		x					
Partner #2 (First, Middle (Maid	den), Last):						
Date of Birth:			*Social Security number;				
Bate of Bitti.			Joseph Goden, Names				
	,		0.7	10	7: 0 1		
Home Address (street address	;):		City:	State:	Zip Code:		
Telephone Number (including	area code):						
SECTION E: OTHER E	NTITY - NO	OT INCORPORA	TED (Special Instruction	ons: These are	programs		
operated by School Board	ds or city/cou		, before and after school				
and other non-incorporate	ed entities.)						
Name of Entity:							
ORANGE COUNTY,	FLORIDA			10			
Entity's Designated Represent	tative (First, Mi	ddle and/or Maiden,	Last):				
Address of Entity (street addre	ess):	6	City:	State:	Zip Code:		
201 SOUTH ROSALI		IF	ORLANDO	FL	32801		
			CITE/TITE		02001		
Telephone Number (including	area code):	74					
(407)836-6590							

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION F: ON-SITE DIRECTO An On-site Director holds a Director of to be on-site for the majority of opera multiple before-school and after-school number of children enrolled; or, (b) M	Credential, is responsit iting hours. A Multi-Site ool programs for a sing	ole for the day-to-day operation e Director holds a Director Cre le organization as follows: (a)	n of the facted ential and Three sites	ility and is required I supervises s regardless of the
Name (First, Middle and/or Maiden, Last): Wilna Francois				
Date of Birth:		*Social Security number:		
Home Address:		City:	State:	Zip Code:
586 Homes Grove Drive		Winter Garden	FL	34787
Cell Phone Number (including area code): (407)923-4033	If applicable, name of M	ulti-Site Programs and enrollment		
PART 3: ATTESTATION (To be	completed by all a	oplicants)		
Has the owner, applicant, or director the subject of a disciplinary action, or	ever had a license der been fined while emp	nied, revoked, or suspended in	any state o	or jurisdiction, been
I hereby attest that the information continued that the inform	arty to ownership ever other than a driver's li re, what type of license	held a license (child care, fost icense? e, license number, and under w	er care, co	Initial smetology, etc.)
Pursuant to section 402.3054, F.S., upon screening, using level 2 stand provider, it is the responsibility of thaccordingly, and parents/guardians conducted by the child enrichment s	ards in Chapter 435, ne director to ensure provide written cons	F.S. If this facility utilizes a that the child enrichment se	a child enr rvice provi	ichment service ider is screened
The Health Insurance Portability an information must be protected from the public and to otherwise assure that you agree to comply with the rechildren's health records in your post	disclosure and maint the privacy of such in equirements of HIPAA	tained in a manner to prever formation. Your signature of	nt inadvert on this app	ent disclosure to dication indicates
In accordance with s. 402.319(3), F with the provisions of s. 39.201, F.S Jerry L. Demings , A do hereby affirm that all child care p	S., regarding the requ pplicant of John H. Br	irements of a mandated rep idges Head Start	orter. By	
Pursuant to section 435.05(3), F.S., of Chapter 435, F.S., regarding the Jerry L. Demings , Appattest under penalty of perjury that all	statutory requirement plicant of John H. Brid	ts for background screening	j. By sign Child Care	ing below, I Facility, do hereby
Ryung. B.Wor. Signature of Applicant	Ro Com	January 11, 2022 Date		

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information.

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law.

9	Signature of	WWW . BWO.	A 's Designated Repre	esentati	January Date	11, 2022	- COUNTY TO
Person	completin Name (plea	g application if otherse print):	er than Owner or	Orga	nization's Designated R	eprese	ntative.
	Title/Position	on/Relationship to the C	Owner:				
	Telephone	Number, including area	code:	*			
	- 110-	D o l	Not Write Below t	this Li	ne – Official Use Only		
Date Fe	e Received:	Amount:	Check Number:	Rece	olved by Signature/Initials:	Date F	Fee Forwarded to Fiscal Office:
	Offender Add ffender.fdle.s	ress Cross-Reference state.fl.us);	Date of Search:		Conducted by Signature/Ini	tials:	Exact Address Match: Yes No
				2			

MYFLFAMILIES.COM

BCC Mtg. Date: Jan. 11, 2022 APPLICATION FOR A LICENSE
TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

Instructions: All information on this application must be truthful and correct. Complete this application in its entirety, as appropriate. Not all sections apply. Incomplete applications will not be accepted. Please contact the licensing agency if there are any questions relating to this application

PART 1: PROGRAM INFORMATION (th	his se	ction must be co	mpleted in	its entirety	/)	
Application Type Initial [(choose one): License		enewal ear: 2022	Chang Owner		Revision of Existing License	
Name of Facility as it is to appear on license: Callahan Head Start			Telepho (includi	one Number ng area code):)836-6735		ate Phone Number:
Street Address of Facility (physical address): 101 North Parramore		City: Orlando	1 (12)	County: Zip Code: ORANGE 32805		
Mailing Address of Facility, if different (include city a 2100 EAST MICHIGAN STREET ORI						
E-Mail Address: Toinette.Stenson@ocfl.net				(40	7)836	luding area code): 5-2877
Is this facility located in or adjacent to the home of the Yes V N owner/operator?	o t	f yes , all household background screening of family members w	ng completed	d. Please atta	ach a li	st Capacity:
Opening Time: 7:00 PM 7:00 PM 7:00 Closing Time: 6:00 PM 6:00 PM 6:00	dnesda	Thursday AM AM 7:00 PM AM AM 6:00 PM	Friday A 7:00 P	Saturo M M M	lay] AM] PM] AM] PM	Sunday AM PM AM PM
	n Zone	Public/Non-P	ublic School	VPK	So	chool Readiness
Full Day Half Day Drop-	-In	Night Care Befo	ore School	After School	W	eekend
Infant Care (0-1) Food Served	t t	Transportation				



PART 2: OWNERSHIP TYPE (check	one)					
Individual Ownership – Not incorporated	Individual Owr	vner				complete Sections and F
Corporation	Corporation D	ocume	ntation required		С	omplete Sections and F
Limited Liability Company (LLC)	LLC Documen	tation r	equired			omplete Sections and F
Partnership – Not Incorporated	Partnership D	ocumer	ntation required			omplete Sections and F
Other Entity – Not Incorporated			ocal Government, Befor ks and Recreation, Fai			omplete Sections and F
SECTION A: INDIVIDUAL OWNERSH Name (First, Middle and/or Maiden, Last):	IIP – NOT INC			ruction	ns: O	ne owner)
Date of Birth:		*Socia	I Security number:			
Home Address:		City: State		э:	Zip Code:	
Telephone Number (including area code):						
SECTION B: CORPORATION (Specific Articles of Incorporation, which must include member of the Board of Directors. Also attained to continuously maintain a registere license. For RENEWAL applications for confidence of Authorization from the Department of Statement of Corporation:	ude the names, ach the name a d office and/or r hild care licensu	the title nd telep egister ure, atta ough S	phone number of the co ed agent in Florida is g ach a current copy of C	elephon rporation	e nun on's re for rev	nber for each egistered agent. vocation of this
Address of Corporation:		Incorp	orated in which State?			
Address of Corporation.		If out-o	of-state, is the corporation	register	gister	prior to
City: State: Z	ip Code:	Teleph	one Number (including ar		• •	
Designated Corporate Representative:			Date of Birth:		*Soci	al Security Number
Home Address:		City:		State	e:	Zip Code:

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S. *Social security numbers are used for identification purposes when performing the background screening required by ss. 402.305 and 402.308, F.S.

SECTION C: LIMITED LI, licensure, attach Articles of number for each member of registered agent. Failure to for revocation of this license. Certificate of Status/Certificate	f Organiza the Comp continuou For REN	ation, which must bany. Also attach b usly maintain a reg EWAL application	include the the name a istered off s for child epartment	and telephone num ice and/or registere care licensure, atta of State (available	ffice, addre ber of the o ed agent in ch a curren	ess, and telephone corporation's Florida is grounds t copy of		
Name of Company:		Company	and FEIN #:					
Address of Company:			Organized	in which State?				
			Yes	NO submi	please registe tting an applic	er prior to		
City:	State:	Zip Code:	Telephone	Number (including ar	rea code):			
Designated Company Representa	tive:		D	ate of Birth:	*So	ocial Security Number:		
Home Address:			City:		State:	Zip Code:		
SECTION D: PARTNERS Partnership Agreement annu Partner #1 (First, Middle (Maiden)	ually. Atta							
Date of Birth:			*Social Security number:					
Home Address (street address):			City:		State:	Zip Code:		
Telephone Number (including area	a code):							
Partner #2 (First, Middle (Maiden)	, Last):							
Date of Birth:			*Social Se	ecurity number:				
Home Address (street address):			City:		State:	Zip Code:		
Telephone Number (including area	a code):							
SECTION E: OTHER EN operated by School Boards and other non-incorporated	or city/cou							
Name of Entity: ORANGE COUNTY, FL	ORIDA							
Entity's Designated Representativ	e (First, Mid	ddle and/or Maiden, L	ast):					
Address of Entity (street address) 201 SOUTH ROSALINE	AVENU	JE	City:	NDO	State:	Zip Code: 32801		
Telephone Number (including area (407)836-6590	a code):							

SECTION F: ON-SITE DIRECTO An On-site Director holds a Director C to be on-site for the majority of operat multiple before-school and after-scho number of children enrolled; or, (b) M Name (First, Middle and/or Maiden, Last):	Credential, is responsil ting hours. A Multi-Sit ol programs for a sing	ole for the day-to-da e Director holds a D le organization as f	ay operation of Director Crede ollows: (a) The	of the faci ential and nree sites	lity and is required supervises regardless of the		
Toinette Stenson							
Date of Birth:		*Social Security num	nber:				
Home Address:		City:		State:	Zip Code:		
2633 Breezewind Drive		Orlando		FL	32839		
Cell Phone Number (including area code): (321)388-7169	If applicable, name of M	lulti-Site Programs an	d enrollment:	19122			
PART 3: ATTESTATION (To be	completed by all a	pplicants)					
Has the owner, applicant, or director the subject of a disciplinary action, or Yes No If yes, please		loyed in a child care	e facility?	ny state o	or jurisdiction, been		
I hereby attest that the information contained in this section is truthful and correct under penalty of perjury. Initial Have you or anyone identified as a party to ownership ever held a license (child care, foster care, cosmetology, etc.) with any state agency in any capacity other than a driver's license? Yes No If yes, where, what type of license, license number, and under what name? Facility Certificate of License, No. C09OR0207 East Orange Head Start							
Pursuant to section 402.3054, F.S., upon screening, using level 2 standa provider, it is the responsibility of the accordingly, and parents/guardians conducted by the child enrichment s	ards in Chapter 435, e director to ensure provide written cons	F.S. If this facilit that the child enri	ty utilizes a c chment serv	child enri ice provi	chment service der is screened		
The Health Insurance Portability and information must be protected from the public and to otherwise assure that you agree to comply with the rechildren's health records in your pos	disclosure and main the privacy of such in equirements of HIPA	tained in a manne formation. Your	r to prevent signature on	inadvert this app	ent disclosure to lication indicates		
In accordance with s. 402.319(3), F. with the provisions of s. 39.201, F.S. Jerry L. Demings , Apdo hereby affirm that all child care p	i., regarding the requ oplicant of Callahan I	irements of a mai Head Start	ndated repor	ter. By			
Pursuant to section 435.05(3), F.S., e of Chapter 435, F.S., regarding the Jerry L. Demings , App attest under penalty of perjury that all	statutory requirement of Callahan He	nts for background ead Start	l screening. Ch	By signi	ing below, I Facility, do hereby		
Brywww. Bwo. Signature of Applicant	By County Co	January 11, 2	2022				

Pursuant to s. 39.604, F.S., each provider must acknowledge receipt of the reporting requirements and educational stability provisions of the "Rilya Wilson Act." Your signature on this application indicates acknowledgement of receipt of such information. Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Your signature on this application indicates your understanding and compliance with this law. January 11, 2022 Signature of Owner or Organization's Designated Representative Date Person completing application if other than Owner or Organization's Designated Representative. Name (please print): Title/Position/Relationship to the Owner: Telephone Number, including area code:

Do Not Write Below this Line - Official Use Only

Dațe Fee Received:	Amount:	Check Number:	Received by Signature/Ini	itials; Date	Fee Forwarded to Fiscal Office:
Sexual Offender Add (http://offender.fdle.s		ence Date of Search:	Conducted by Signa	ture/Initials:	Exact Address Match: Yes No