

Interoffice Memorandum

December 22, 2022

AGENDA ITEM

- TO: Mayor Jerry L. Demings -AND-County Commissioners
- THRU: Dr. Tracy Salem, Deputy Director
- FROM: Sonya L. Hill, Manager Head Start Division Contact: Sandra Moore (407) 836-8913
- SUBJECT: Consent Agenda Item January 24, 2023 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 2022-2023 school year. The licenses fees will be paid with Head Start funds.

Center Name	Expiration Date	Fee
1. Pine Hills Head Start	March 12, 2023	\$100
2. Hal P. Marston Head Start	March 16, 2023	\$100
3. Bithlo Head Start	March 23, 2023	\$60
4. East Orange Head Start	April 1, 2023	\$100
5. Southwood Head Start	April 30, 2023	\$100
6. John H. Bridges Head Start	May 7, 2023	\$100
7. Callahan Head Start	July 1, 2023	\$ 62
8. Washington Shores Early Learning Center	July 6, 2023	\$100

Consent Agenda Item – January 24, 2023 Florida Department of Children and Families Applications for Renewal Licenses to Operate Child Care Facilities Page 2

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

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, Hal P. Marston, Bithlo, East Orange, Southwood, John H. Bridges, Callahan, and Washington Shores Early Learning Center Head Start sites.

SLH/smm:jamh



APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023



APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

MYFEFAMILIES.COM Press space bar (or left mouse click) to check a box; press space bar (or left mouse click) to uncheck a box. **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

FOR LICENSE RENEWALS ONLY: Renewal of this license is contingent upon the payment of any fines previously imposed as a sanction against this license that were not contested, or that were affirmed at an administrative hearing. If, at the time of this license renewal application, there is a pending administrative hearing resulting from a proposed fine, it shall not affect the renewal of this license.

PART 1: PROGRAM INFORMATION (this section must be completed in its entirety)							
Application Type	tial 🖌 *F	Renewal	Change	Change of		Revision of	
(choose one):	ense Y	ear: 2022-23	Owners	Ownership Existir		ng License	
Name of Facility as it is to appear on lic	cense:			Telephone Number Alternate (including area code):			
Pine Hills Head Start			· · ·	(407)249-6370		(407)254-9112	
Street Address of Facility (physical add	ress):	City:		County:		Code:	
6408 Jennings Road		Orlando		Orange	e 3	2818	
Mailing Address of Facility, if different							
2100 East Michigan Stre	et, Orlando, FL 3	2806					
E-Mail Address:		1		FAX Numbe	er (including	area code):	
Tiffany.Brown@ocfl.net				(40	7)836-8	513	
Is this facility located in or		If yes, all household				Maximum	
	Yes 🗹 No	background screeni of family members v				Capacity: 255	
owner/operator? Days and Hours of Operation	– please check AN			es and dates	OI DIITIT.	200	
	piedee encontrait						
24 Hour Care Mondav Tu	esday Wednesd	lay Thursday	Friday	Saturda	aiv.	Sunday	
		AM M AM	A		AM		
Opening 🔄							
Time: <u>7:00</u> PM <u>7:00</u>	PM <u>7:00</u>	РМ <u>7:00</u> РМ	<u>7:00</u> PI	M	PM	PM	
		AM AM		v 🗌	AM	MA 🗌	
Closing Time: <u>6:00</u> PM <u>6:00</u>		м 6:00 🔽 РМ	6:00 PM	v 🗌	PM	 □ PM	
		_					
	chool 🛛 🗹 12 Mont ar Only	hs Other:					
Program Designations:							
Faith Based VPK School Readiness							
Check all service options that apply:							
Full Day Half Day Drop-In Night Care Before School After School Weekend							
Infant Care (0-1) Food Served Transportation							
						i stati	



PART 2: OWNERSHIP TYPE (check one)				
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F		
	Corporation Documentation required	Complete Sections B and F		
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F		
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F		
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F		

*Social Security numb	er:	
City:	State:	Zip Code:
		*Social Security number: City: State:

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SECTION B: CORPORA Articles of Incorporation, or member of the Board of Direct Failure to continuously main license. For RENEWAL app of Authorization from the De	which must ectors. Also tain a regis	include the name attach the name stered office and/ or child care licer	es, the title and teleph or registere nsure, attac	one number of the corp d agent in Florida is gro h a current copy of Cert	phone oration unds f	e number for each n's registered agent. or revocation of this
Name of Corporation:			Corpora	te 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:	Zip Code:	Telephone Number (including area code):			
Designated Corporate Representation	ve:	F	1	Date of Birth:		*Social 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.

CF-FSP 5017, PDF 05/2019 [65C-22.001(1)(a), F.A.C.]

SECTION C: LIMITED L licensure, attach Articles of number for each member of registered agent. Failure to for revocation of this license Certificate of Status/Certificat	of Organiz of the Comp continuou e. For REN	ation, which muspany. Also attach Isly maintain a re IEWAL application	st include the name gistered o ons for ch	the names, the title and telephone nu ffice and/or registe ild care licensure, a	e/office, add mber of the red agent in ttach a curre	corporation's n Florida is grounds ent copy of
Name of Company:				iny and FEIN #:		
Address of Company:			Organi	zed in which State?		
					registered in the no, please regis bmitting an ap	ster prior to
City:	State:	Zip Code:	Teleph	one Number (including a	area code):	
Designated Company Representativ	/e:			Date of Birth:		*Social Security Number:
Home Address:			City:	1	State:	Zip Code:
Partner #1 (First, Middle (Maiden), I Date of Birth:	_ast).		*Socia	I Security number:		
Date of Birth:			*Socia	I Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area	code):					
Partner #2 (First, Middle (Maiden), I	_ast):					
Date of Birth:			*Socia	I Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area	code):					
SECTION E: OTHER EN operated by School Boards and other non-incorporated Name of Entity:	or city/cou			(Special Instructio and after school pr		
Orange County, Florida		and/ or Maidon J act	Ν.			
Entity's Designated Representative Tiffany Price-Brown	(First, Middle	and/ or Maiden, Last	():			
Address of Entity (street address):			City:		State	Zip Code:
201 South Rosalind Av	/enue			ando	FL	
Telephone Number (including area (407)836-6590	code):		l		ł	

Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402 .305(2), F.S.

SECTION F: ON-SITE DIRECTO 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 responsil ting hours. A Multi-Site ool programs for a sing	ble for the day-to-day e Director holds a Dir le organization as fo	operation of the ector Credentia llows: (a) Three	e facilit al and su sites re	y and is required upervises gardless of the
Name (First, Middle and/or Maiden, Last):					
Tiffany Price-Brown Date of Birth:		*Social Security numb	er:		
	·				
Home Address:		^{City:} Mascotte	Sta	ite: FL	Zip Code: 34753
15351 Whitetail Loop Cell Phone Number (including area code):	If applicable, name of Mul			L	54755
(407)467-7666					
PART 3: ATTESTATION (To be Has the owner, applicant, or director the subject of a disciplinary action, or Yes Yes No If yes, plea	ever had a license der	nied, revoked, or sus ployed in a child care	facility?	state or	jurisdiction, been
I hereby attest that the information con- Have you or anyone identified as a p with any state agency in any capacity Yes V No If yes, whe	arty to ownership ever	held a license (child license?	care, foster car	re, cosn	Initial
Pine Hills Head Start, Certifi		90R0243			
Pursuant to section 402.3054, F.S., upon screening, using level 2 stands provider, it is the responsibility of the accordingly, and parents/guardians conducted by the child enrichment s	ards in Chapter 435, I e director to ensure th provide written conse	F.S. If this facility ut hat the child enrichr	tilizes a child e ment service pr	nrichm rovider	ent service 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 re children's health records in your po	disclosure and maint he privacy of such inf quirements of HIPAA	ained in a manner to ormation. Your sigr	o prevent inadv nature on this a	vertent applicat	disclosure to ion indicates
In accordance with s. 402.319(3), F. with the provisions of s. 39.201, F. Jerry L. Demings, A do hereby affirm that all child care	S., regarding the req pplicant of <u>Pine Hills</u>	uirements of a man Head Start	dated reporter	r. By s	
Pursuant to section 435.05(3), F.S., e Chapter 435, F.S., regarding the statu Jerry L. Demings , Ap attest under penalty of perjury that a	tory requirements for b plicant of Pine Hills H	ackground screening lead Start	g. By signing be Child	elow, I Care	cility_do_hereby
	k	24 Aan 2 Date		VOS- ORP	E S
Background screening of owners, operators, and dire *Social security numbers are used for identification pu				2.308, F.S.	CE COUNTRY FLORE

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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.

Designated Representative Go Back To Person completing application if other than Owner or Organization's Designated Representation Name (please print): Title/Position/Relationship to the Owner: Telephone Number, including area code: 1

Do Not Write Below this Line - Official Use Only

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date Fe	e Forwarded to Fiscal Office:
				4iala:	Typet Address Match
Sexual Offender Addr (http://offender.fdle.sta		Date of Search:	Conducted by Signature/Ini		Exact Address Match:



APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023

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.

FOR LICENSE RENEWALS ONLY: Renewal of this license is contingent upon the payment of any fines previously imposed as a sanction against this license that were not contested, or that were affirmed at an administrative hearing. If, at the time of this license renewal application, there is a pending administrative hearing resulting from a proposed fine, it shall not affect the renewal of this license.

PART 1: PROGRAM INFORMATION (this section must be completed in its entirety)							
Application Type	'Renewal	Change of	f R	evision of			
	Year: 2022-23	Ownership	Ownership Existing				
Name of Facility as it is to appear on license:		Telephone N (including ar		nate Phone Number:			
Hal P. Marston Head Start	rt			07)836-8455			
Street Address of Facility (physical address):	City:	Cou	inty:	Zip Code:			
3933 W.D. Judge Drive	Orlando		Orange	32808			
Mailing Address of Facility, if different (include city and zip	code):	I					
2100 East Michigan Street, Orlando, FL	32806						
E-Mail Address:			FAX Number (incl	uding area code):			
Jeneil.Parker@ocfl.net			(407)83	6-8440			
Is this facility located in or	If yes, all household						
adjacent to the home of the Yes No	background screening						
	owner/operator? of family members with their names and dates of birth. 130 Days and Hours of Operation – please check AM or PM as applicable:						
24 Hour Care							
Monday Tuesday Wednes	sday Thursday	Friday	Saturday	Sunday			
	AM AM	AM					
Opening 📃 🔄							
Time: 7:00 PM 7:00 PM 7:00		<u>7:00</u> PM_	PM_	PM			
	AM AM	AM	AM	AM			
Time: 6:00 PM 6:00 PM 6:00	РМ <u>6:00</u> РМ	6:00 PM_	PM_	PM			
Months of Operation: School 12 Mor Year Only	nths Other:						
Program Designations:							
Faith Based VPK School Readiness							
Check all service options that apply:							
Full Day Half Day Drop-In	Night Care Bef	ore School Afte	er School V	Veekend			
Infant Care (0-1) Food Served Transportation							



Background screening of owners, operators, and directors who by definition are childcare personnel is required by s. 402.305(2), F.S.

PART 2: OWNERSHIP TYPE (check one)				
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F		
Corporation	Corporation Documentation required	Complete Sections B and F		
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F		
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F		
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F		

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security numb	ber:	
Home Address:	City:	State:	Zip Code:
Telephone Number (including area code):			

SECTION B: CORPORATION (Special Instructions: Upon initial application for childcare licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for childcare licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:			Corporate and FEIN #:				
Address of Corporation:			Incorporated in which State?				
					o registered in o, please reg omitting an a	sister prior to	
City:	State:	Zip Code:	Telephone Number (including area code):				
Designated Corporate Repr	esentative:			Date of Birth:		*Social Security Number:	
Home Address:			City:		State	e: Zip Code:	

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CF-FSP 5017, PDF 05/2019 [65C-22.001(1)(a), F.A.C.]

SECTION C: LIMITED LIA licensure, attach Articles of number for each member of the registered agent. Failure to con- for revocation of this license. of Status/Certificate of Authori	Organization the Composition continuous For REN	ation, which must bany. Also attach ti sly maintain a regi IEWAL application	include the he name an istered offic ns for childc	d telephone number e and/or registered a are licensure, attach a	e, add of the gent in a curre	dress, corpo n Flori ent cop	and telephone oration's ida is grounds
Name of Company:				and FEIN #:		·)·	
Address of Company:			Organized	in which State?			
			Yes	Subiniti	ase regi 1g an a	ister prid	or to
City:	State:	Zip Code:	Telephone	Number (including area co	de):		
Designated Company Representative:			D	ate of Birth:		*Socia	I Security Number:
Home Address:			City:		State	:	Zip Code:
SECTION D: PARTNERSI Partnership Agreement annua Partner #1 (First, Middle (Maiden), Las	ally. Atta		ets as applic				
Date or Birth:			*Social Se	curity number:			
Home Address (street address):			City: Stat			:	Zip Code:
Telephone Number (including area coo	je):				1		L
Partner #2 (First, Middle (Maiden), Las	st):						
Date of Birth:			*Social Se	curity number:			
Home Address (street address):			City:		State	:	Zip Code:
Telephone Number (including area coo	de):						
SECTION E: OTHER ENT operated by School Boards of and other non-incorporated e Name of Entity: Orange County, Florida Entity's Designated Representative (Fi	entities.)	unty municipalities,	TED (Sp before and	ecial Instructions: T I after school progran	hese ns, fai	are pr ith -ba	ograms ised programs
Jeneil Parker Address of Entity (street address):			Citur		Stata		Zin Codo:
201 South Rosalind Ave	nue		City: Orland	lo	State		Zip Code: 32801
Telephone Number (including area coc (407)836-6590	ie):		1				

SECTION F: ON-SITE DIRECTO 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 responsil ting hours. A Multi-Site ool programs for a sing	ble for the day-to-day Director holds a Dire le organization as foll	operation of the fa ector Credential ar ows: (a) Three site	acility and is required nd supervises es regardless of the
Name (First, Middle and/or Maiden, Last): Jeneil.Parker				
Date of Birth:		*Social Security numbe	r:	
Home Address: 14722 Kristenright Lane		^{City:} Orlando	State: FL	Zip Code: 32826
Cell Phone Number (including area code): (954)410-8512	If applicable, name of Mul			32020
PART 3: ATTESTATION (To be	completed by all ap	oplicants)		
Has the owner, applicant, or director the subject of a disciplinary action, or Yes Yes No If yes, plea		loyed in a child care f	acility?	,
I hereby attest that the information con- Have you or anyone identified as a p with any state agency in any capacity Yes No If yes, whe Hal P. Marston Head Start, 0	arty to ownership ever o other than a driver's l re, what type of license	held a license (child icense? e, license number, an	care, foster care, o	Initial cosmetology, etc.)
Pursuant to section 402.3054, F.S., upon screening, using level 2 standa provider, it is the responsibility of the accordingly, and parents/guardians by the child enrichment service prov The Health Insurance Portability and	ards in Chapter 435, F e director to ensure th provide written conse vider.	F.S. If this facility utiles the child enrichment before a child ma	lizes a child enric ent service provi y participate in a	hment service der is screened ctivities conducted
information must be protected from o public and to otherwise assure the p you agree to comply with the require health records in your possession.	disclosure and mainta rivacy of such inform	ained in a manner to ation. Your signature	prevent inadverte e on this applicat	ent disclosure to the ion indicates that
In accordance with s. 402.319(3), F the provisions of s. 39.201, F.S., reg				
Jerry L. Demings, Applied to the second secon	oplicant of <u>Hal P. Mar</u> connel are in complia	ston Head Start nce with s. 39.201,	C F.S.	Child Care Facility, do
Pursuant to section 435.05(3), F.S., each 435, F.S., regarding the statutory required the statutory required to the statut	irements for backgrour plicant of Hal P. Mars	nd screening. By sign ton Head Start	ing below, I Child	Re Recitity; de tereb
Background screening of owners, operators, and dire *Social security numbers are used for identification put	-			FE (MINITY ELOP

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 Designate	ed Representative	_ 2		M 23 Date	OF COUNT	YCON
				Go Bac	k To Page 2	F A
		i-otion?o l	Decianat	had Danna	2	-
completing application if other than Name (please print):	Owner or Organi	ization's I	Designat	ted Repre	sentitive.	NITY FLO
completing application if other than Name (please print): Title/Position/Relationship to the Owner:	Owner or Organi	ization's I	Designat	ted Repre		NITY FL

Do Not Write Below this Line - Official Use Only

Date Fee Received:	Amount:	Check Number:	Receive	ed by Signature/Initials:	Date Fe	ee Forwarded to Fiscal Office:
	-					
Sexual Offender Addre	••••	Date of Search:	C	onducted by Signature/Initials	:.	Exact Address Match:
(http://offender.fdle.sta	te.fl.us):					Yes No

Background screening of owners, operators, and directors who by definition are childcare 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.

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APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023

APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

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Application Type	Initial	*Renewal	Change	of	Revis	ion of
(Choose one):	License	Year: 2022-23	Owners	hip	Existi	ng License
Name of Facility as it is to	appear on license:			e Number	Alternate F	Phone Number:
Bithlo Head Star	t			area code): 383-5962	(407)	254-1928
Street Address of Facility	(physical address):	City:	City: County:			Code:
18501 Washingt	on Avenue	Orlando	Orlando Orango			2820
Mailing Address of Fa	cility, if different (include o	ity and zip code):				
2100 East Michi	gan Street, Orlan	do, FL 32806				
E-Mail Address:				FAX Numbe	er (including	area code):
Teri.Watts@ocfl	.net			(40	7)836-1	926
Is this facility located	in or	If yes, all househ	old members mu	ust be identif	ied, and	Maximum
adjacent to the home owner/operator?	of the Yes	No background scree of family member	ning completed	Please atta	ich a list	Capacity: 100
Days and Hours of	Operation – please	check AM or PM as applica	able:			
24 Hour Care						
Monday	Tuesday	Wednesday Thursday	Friday	Saturda	av	Sunday
	MA AM	MAM MAN			AM	MA
Opening Time: 7:00	РМ РМ РМ	7:00 PM _7:00 PM	1 PN	<u>ا</u>	PM	PM
	M □AM 1 6:00 √PM 6:0				AM PM	
Months of Operatio		12 Months Other:				
	ons:					
Program Designation						
	Head Start	Urban Zone Public/Nor	-Public School		Schoo	l Readines
Faith Based		Urban Zone Public/Nor	n-Public School		Schoo	l Readines
	otions that apply:			VPK	School School	
Faith Based Check all service o	otions that apply:			_		
Faith Based Check all service of Full Day	Ditions that apply:	Drop-In Night Care E		_		



Background screening of owners, operators, and directors who by definition are childcare personnel is required by s. 402 .305(2), F.S.

PART 2: OWNERSHIP TYPE (check one)						
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F				
Corporation	Corporation Documentation required	Complete Sections B and F				
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F				
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F				
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F				

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security numb	er:	
Home Address:	City:	State:	Zip Code:
Telephone Number (including area code):			

SECTION B: CORPORATION (Special Instructions: Upon initial application for childcare licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for childcare licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:			Corporate and FEIN #:				
Address of Corporation:			Incorporated in which State?				
					registered ir o, please reg mitting an a	ister pri	or to
City:	State:	Zip Code:	Teleph	one Number (including an	ea code):		
Designated Corporate R	lepresentative:			Date of Birth:		*Socia	al Security Number:
Home Address:			City:		State) 9:	Zip Code:

SECTION C: LIMITED LIA licensure, attach Articles of number for each member of registered agent. Failure to of for revocation of this license. of Status/Certificate of Author	Organizathe Componization	ation, which musi bany. Also attach sly maintain a reg EWAL applicatio	t include the name istered o ns for ch	and telephone number ffice and/or registered a ldcare licensure, attach	of the of agent in a current	ess, and telephone corporation's Florida is grounds at copy of Certificate
Name of Company:	a contraction in the	and Dopartmen		iny and FEIN #:		
Address of Company:			Organi	zed in which State?		
				es No submitt	ease regist	er prior to
City:	State:	Zip Code:	Teleph	one Number (including area c	ode):	
Designated Company Representative	6			Date of Birth:	*	Social Security Number:
Home Address:			City:		State:	Zip Code:
SECTION D: PARTNERS Partnership Agreement annu Partner #1 (First, Middle (Maiden), La	ually. Atta			(Special Instructions: / plicable if more than tw		
Date of Birth:			*Socia	I Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area co	ode):					
Partner #2 (First, Middle (Maiden), La	ist):					
Date of Birth:			*Socia	I Security number:		
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area co	ode):					
SECTION E: OTHER EN operated by School Boards and other non-incorporated Name of Entity:	or city/cou					
Orange County, Florida						
Entity's Designated Representative (F Teri Watts	First, Middle	and/ or Maiden, Last)				
Address of Entity (street address):			City:		State:	
201 South Rosalind Ave Telephone Number (including area co			Orl	ando	FL	32801
(407)836-6590	ude):					

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-scho number of children enrolled; or, (b) M Name (First, Middle and/or Maiden, Last):	Credential, is responsil ting hours. A Multi-Site ool programs for a sing	ble for the day-to-day e Director holds a Dir le organization as fol	operation of the ector Credential llows: (a) Three s	e facility and is requ and supervises sites regardless of	uired the
Teri Watts					
Date of Birth:		*Social Security number	er:		
Home Address:		City:	State	· ·	
4170 Hemlock Lane		Titusville	Fl	32780	
Cell Phone Number (including area code): (407)383-5962	If applicable, name of Mul	ti-Site Programs and enro	llment:		
PART 3: ATTESTATION (To be	completed by all a	oplicants)			
Has the owner, applicant, or director the subject of a disciplinary action, or Yes No If yes, plea		loyed in a childcare	facility?	ate or jurisdiction,	been .
I hereby attest that the information of Have you or anyone identified as a p with any state agency in any capacity Yes No If yes, whe Bithlo Head Start Certificate	arty to ownership ever y other than a driver's re, what type of licens	held a license (child license? e, license number, ar	care, foster care	Initia , cosmetology, etc.	1
Pursuant to section 402.3054, F.S., upon screening, using level 2 stands provider, it is the responsibility of the accordingly, and parents/guardians by the child enrichment service pro- The Health Insurance Portability and information must be protected from the public and to otherwise assure t that you agree to comply with the re children's health records in your po	ards in Chapter 435, I e director to ensure the provide written conservider. d Accountability Act (disclosure and maint he privacy of such inf quirements of HIPAA	F.S. If this facility ut hat the child enrichr ent before a child m HIPAA) requires tha ained in a manner to formation. Your sigr	tilizes a child en ment service pro ay participate ir at personally ide prevent inadve nature on this ap	richment service ovider is screened a activities condu- entifiable health ertent disclosure f oplication indicate	i cted to
In accordance with s. 402.319(3), F the provisions of s. 39.201, F.S., reg	.S., each childcare fa garding the requireme	acility must annually ents of a mandated	r submit an affid reporter. By sig	lavit of complianc gning below, I,	e with
hereby affirm that all child care per		ance with s. 39.201,		_Child Care Facil	-
Pursuant to section 435.05(3), F.S., Chapter 435, F.S., regarding the statu Jerry L. Demings, Ap attest under penalty of perjury that a Bignature of Applicant Background screening of owners, operators, and direct	tory requirements for b plicant of <u>Bithlo Head</u> Il child care personnel	ackground screening d <u>Start</u> l are in compliance v <u>24</u> Am 2 Date	g. By signing bel Child (with the provision	ow Facility do	Tess of
*Social security numbers are used for identification pu	irposes when performing the bar	ckground screening required l	by ss. 402.305 and 402.	308, F.S. CAJARTY	CPN.

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.

By M. BM Signature of Owner or Organization's D	Jesignated Representative		23 Saci: To Page 2
Person completing application if othe Name (please print):	er than Owner or Organi	zation's Designated Re	epresentative.
Title/Position/Relationship to the Owne	ər:		
Telephone Number, including area coo	de:		· .

Do Not Write Below this Line – Official Use Only

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date F	ee Forwarded to Fiscal Office:
Sexual Offender Addre (http://offender.fdle.stat		Date of Search:	Conducted by Signature/Initials		Exact Address Match:



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

FOR LICENSE RENEWALS ONLY: Renewal of this license is contingent upon the payment of any fines previously imposed as a sanction against this license that were not contested, or that were affirmed at an administrative hearing. If, at the time of this license renewal application, there is a pending administrative hearing resulting from a proposed fine, it shall not affect the renewal of this license.

PART 1: PROGRAM INFORMATION (this section must be completed in its entirety)							
Application Type	Renewal	Change of		Revis	ion of		
(choose one): License Y	/ear: 2022-23	Ownershi	ip	Existi	ng License		
Name of Facility as it is to appear on license:		Telephone I (including a		Alternate F	hone Number:		
East Orange Head Start			39-4261	(407)2	254-9713		
Street Address of Facility (physical address):	City:	Co	unty:	Zip	Code:		
12050 East Colonial Drive	Orlando		Orange	32	2826		
Mailing Address of Facility, if different (include city and zip c		I					
2100 East Michigan Street, Orlando, FL 3	32806						
E-Mail Address:			FAX Numbe	r (including	area code):		
Yira.Rodriguez@ocfl.net			(407	7)836-29	987		
Is this facility located in or	If yes, all household me				Maximum		
adjacent to the home of the Yes No	background screening				Capacity: 174		
owner/operator? Days and Hours of Operation – please check Al	of family members with	their names	and dates	of dirth.			
24 Hour Care Monday Tuesday Wednes	day Thursday	Friday	Saturda	21/	Sunday		
	AM AM	AM		AM			
Opening 🖳 🖳							
Time: 7:00 PM 7:00 PM 7:00	PM <u>7:00</u> PM <u>7:</u>	<u>00</u> [] PM_		PM	PM		
	AM AM	MA		AM	AM		
Time: 6:00 PM 6:00 PM 6:00	РМ 6:00 🔽 РМ 6:0	00 🔽 PM		PM	PM		
Months of Operation: School 12 Mon							
Year Only Program Designations:							
Faith Based Mead Start Urban Zo	ne Public/Non-Publ	lic School	UVPK [Schoo	l Readiness		
Check all service options that apply:							
Full Day Half Day Drop-In	Night Care Before	School Af	ter School	Week	end		
Infant Care (0-1) Food Served	Transportation						



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.

APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023

PART 2: OWNERSHIP TYPE (check one)						
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F				
Corporation	Corporation Documentation required	Complete Sections B and F				
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F				
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F				
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F				

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security numb		
Home Address:	City:	State:	Zip Code:
Telephone Number (including area code):			

SECTION B: CORPORATION (Special Instructions: Upon initial application for child care licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for child care licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:			Corporate and FEIN #:				
Address of Corporation:			Incorporated in which State?				
			_		registered ir o, please reg omitting an a	ister pri	or to
City:	State:	Zip Code:	Telephone Number (including area code):				
Designated Corporate Re	presentative:			Date of Birth:		*Socia	al Security Number:
Home Address:			City:		State) ə:	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.

SECTION C: LIMITED licensure, attach Article number for each member registered agent. Failure for revocation of this lice Certificate of Status/Cert	er of Organiza er of the Comp e to continuous nse. For REN	ation, which must bany. Also attach sly maintain a re EWAL applicati	st include the name egistered o ions for ch	the names, the t and telephone of frice and/or registic and/or registic and the second	itle/office, add number of the stered agent i e, attach a curr	corporation's n Florida is grounds ent copy of
Name of Company:				any and FEIN #:		
Address of Company:		Organi	zed in which State?			
				of-state, is the compare Yes No	If no, please regi submitting an a	ster prior to
City:	State:	Zip Code:	Teleph	one Number (includir	ng area code):	
Designated Company Represer	ntative:			Date of Birth:		*Social Security Number:
Home Address:			City:	L	State	Zip Code:
SECTION D: PARTN Partnership Agreement Partner #1 (First, Middle (Maide	annually. Atta	OT INCORPOR ch additional sh	RATED eets as ap	(Special Instruc plicable if more t	tions: Attach than two parts	a copy of the ners.)
Date of Birth:			*Socia	I Security number:		
Home Address (street address)	:		City:		State	Zip Code:
Telephone Number (including a	irea code):					
Partner #2 (First, Middle (Maide	⊧n), Last):					
Date of Birth:			*Socia	al Security number:		
Home Address (street address)	ť		City:		State	Zip Code:
Telephone Number (including a	rea code):					
SECTION E: OTHER operated by School Boa and other non-incorpora Name of Entity: Orange County, Flo	ards or city/cou ated entities.)					
Entity's Designated Representa		and/ or Maiden, Las	it):			
Yira Rodriguez						
Address of Entity (street addres			City:	a m d a	State	
201 South Rosalind			Orl	ando	FI	_ 32801
Telephone Number (including a (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.

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SECTION F: ON-SITE DIRECTOR INFORMA An On-site Director holds a Director Credential, is to be on-site for the majority of operating hours. A multiple before-school and after-school programs number of children enrolled; or, (b) More than thre	responsible for the day-to-da Multi-Site Director holds a D for a single organization as fo	y operation of the facil rector Credential and blows: (a) Three sites	lity and is required supervises regardless of the
Name (First, Middle and/or Maiden, Last): Yira Rodriguez			
Date of Birth:	*Social Security numb	per:	
Home Address:	City:	State:	Zip Code:
1225 Roma Court	Orlando	FL	32825
Cell Phone Number (including area code): If applicable, n (407)489-4261	ame of Multi-Site Programs and enr	ollment:	
PART 3: ATTESTATION (To be completed	hy all applicants)		
I hereby attest that the information contained in the Have you or anyone identified as a party to owner	cense denied, revoked, or sus while employed in a child care ttach additional sheet(s) if ne is section is truthful and corre ship ever held a license (child	facility? cessary): ect under penalty of pe	rjury. <u>Y. R.</u> Initial
with any state agency in any capacity other than a Yes No If yes, where, what type	i driver's license? of license, license number, a	nd under what name?	
East Orange Head Start Certificate Nur	mber: C09OR0207		
Pursuant to section 402.3054, F.S., child enrichr upon screening, using level 2 standards in Chapt provider, it is the responsibility of the director to accordingly, and parents/guardians provide writt conducted by the child enrichment service provi	ter 435, F.S. If this facility u ensure that the child enrich en consent before a child m	tilizes a child enrichn ment service provide	nent service r is screened
The Health Insurance Portability and Accountability formation must be protected from disclosure are the public and to otherwise assure the privacy of that you agree to comply with the requirements of children's health records in your possession.	nd maintained in a manner t such information. Your sig	o prevent inadverten nature on this applica	t disclosure to ation indicates
In accordance with s. 402.319(3), F.S., each ch with the provisions of s. 39.201, F.S., regarding Jerry L. Demings, Applicant of <u>E</u> do hereby affirm that all child care personnel are	the requirements of a mar ast Orange Head Start	ndated reporter. By Chi	
Pursuant to section 435.05(3), F.S., each employe Chapter 435, F.S., regarding the statutory requirement Jerry L. Demings, Applicant of Ea attest under penalty of perjury that all child care p	ents for background screenin <u>st Orange Head Start</u>	g. By signing below Child Cate	Facility, do herea

SynM. Burks Signature of Applicant

24 Ann 23 Date

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, COMPART

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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.

or Organization's Designated Representative Go Back To Page Person completing application if other than Owner or Organization's Designated Representation Name (please print): Title/Position/Relationship to the Owner: Telephone Number, including area code:

Do Not Write Below this Line – Official Use Only

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date Fee Forwarded to Fiscal Office:
Sexual Offender Addre (http://offender.fdle.sta		Date of Search:	Conducted by Signature/Initia	als: Exact Address Match:



APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023



APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

MYFLFAMILIES.COM Press space bar (or left mouse click) to check a box; press space bar (or left mouse click) to uncheck a box. 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

FOR LICENSE RENEWALS ONLY: Renewal of this license is contingent upon the payment of any fines previously imposed as a sanction against this license that were not contested, or that were affirmed at an administrative hearing. If, at the time of this license renewal application, there is a pending administrative hearing resulting from a proposed fine, it shall not affect the renewal of this license.

PART 1: PROGRA	M INFORMATION	(this section must be a	completed in its	entirety)		
Application Type	Initial	*Renewal	Change	of [Revisi	on of
(choose one):	License	Year: 2022-23	Ownershi	ip	Existin	ng License
Name of Facility as it is to appear on license:			Telephone	Number		hone Number
Southwood Head	d Start		(including a (407)92	23-7750	(407)2	254-6768
Street Address of Facility (physical address):	City:	Co	ounty:	Zip	Code:
6225 Brookgreen	Avenue	Orlando		Orange	32	809
Mailing Address of Fac	ility, if different (include cit	ty and zip code):				
2100 East Michig	an Street, Orland	do, FL 32806				
E-Mail Address:				FAX Numbe	r (including	area code):
Vivian.Jones-Bu	ton@ocfl.net			(407	7)836-19	34
Is this facility located	-	If yes, all househ	old members mus	t be identifi	ed, and	Maximum
adjacent to the home	of the Yes	No background scree	ening completed. I	Please attac	ch a list	Capacity:
owner/operator?		of family member check AM or PM as applic	s with their names	and dates	of birth.	127
Opening Time: 7:00 P Closing A Time: 6:00 P	MAM M <u>6:00</u> PM <u>6</u>		M Y AM M <u>7:00</u> PM M AM		ay 9 AM PM AM PM	Sunday AM PM AM M M
Months of Operatio	Year Only	12 Months Other:				
Program Designatio	ns:					
Faith Based	Head Start	Jrban Zone Public/No	n-Public School	VPK [Schoo	Readines
Check all service op Full Day Infant Ca	Half Day D		Before School Af	fter School	Week	end]



PART 2: OWNERSHIP TYPE (check one)						
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F				
Corporation	Corporation Documentation required	Complete Sections B and F				
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F				
Partnership - Not Incorporated	Partnership Documentation required	Complete Sections D and F				
Other Entity - Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F				

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security numb	*Social Security number:				
Home Address:	City:	State:	Zip Code:			
Telephone Number (including area code):		I				

SECTION B: CORPORATION (Special Instructions: Upon initial application for child care licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for child care licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:			Corporate and FEIN #:				
Address of Corporation:		Incorporated in which State?					
					registered in b, please reg mitting an a	ister prior to	
City:	State:	Zip Code:	Telephone Number (including area code):				
Designated Corporate Re	presentative:			Date of Birth:		*Social Security Number:	
Home Address:			City:		State	e: Zip Code:	

Background screening of owners, operators, and directors who by definition are childcare personnel is required by s. 402 .305(2), F.S.

licensure, attach number for each registered agent. for revocation of t	Articles of Organiza member of the Comp Failure to continuous his license. For REN	ation, which mu bany. Also attacl sly maintain a re EWAL applicat i	(Special Instructions: Up ist include the names, the t in the name and telephone egistered office and/or registered office and/or registered ions for childcare licensure, ent of State (available through	itle/office, addres number of the co stered agent in Fl , attach a current of	s, and telephone rporation's orida is grounds
Name of Company:			Company and FEIN #:	gir oundraiding).	
Address of Company:			Organized in which State?		
			If out-of-state, is the compa	ny registered in the St If no, please register submitting an applic	prior to
City:	State:	Zip Code:	Telephone Number (includio	ng area code):	
Designated Company F	Representative:		Date of Birth:	*So	cial Security Number:
Home Address:			City:	State:	Zip Code:
Partner #1 (First, Middl Date of Birth:			*Social Security number:		
Home Address (street a	address):		City:	State:	Zip Code:
Telephone Number (ind Partner #2 (First, Middl					
Date of Birth:			*Social Security number:		
Home Address (street a	address):		City:	State:	Zip Code:
Telephone Number (ind	cluding area code):				
operated by Scho	corporated entities.)		RATED (Special Instructer, before and after school	tions: These are programs, faith -	
•	presentative (First, Middle	and/ or Maiden, Las	t):		
Address of Entity (stree 201 South Ros	et address):		City: Orlando	State: FL	Zip Code: 32801

Telephone Number (including area code):

(407)836-6590

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SECTION F: ON-SITE DIRECTO 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 Name (First, Middle and/or Maiden, Last):	Credential, is responsil ting hours. A Multi-Site ol programs for a sing	ble for the day-to-day oper Director holds a Director le organization as follows:	ation of the faci Credential and (a) Three sites	lity and is required supervises regardless of the
Vivian Jones-Burton				
Date of Birth:		*Social Security number:		
Home Address:		City:	State:	Zip Code:
147420 Eaton Street		Eatonville	FL	32751
Cell Phone Number (including area code): (407)923-7750	If applicable, name of Mult	i-Site Programs and enrollment:	,	
PART 3: ATTESTATION (To be	completed by all ap	plicants)		••
Has the owner, applicant, or director the subject of a disciplinary action, or Yes No If yes, plea	been fined while emp		γ?	or junisalction, been
I hereby attest that the information co				Initial
Have you or anyone identified as a pa with any state agency in any capacity Yes No If yes, when	other than a driver's I			
Southwood Head Start, Chile	d Care License C0	9OR0251		
Pursuant to section 402.3054, F.S., upon screening, using level 2 standa provider, it is the responsibility of the accordingly, and parents/guardians by the child enrichment service prov	ards in Chapter 435, F director to ensure th provide written conse	S. If this facility utilizes at the child enrichment s	a child enrichr service provide	ment service er is screened
The Health Insurance Portability and information must be protected from of the public and to otherwise assure th that you agree to comply with the red children's health records in your pos	disclosure and maintane privacy of such info quirements of HIPAA	ained in a manner to prev ormation. Your signature	ent inadverten on this application	it disclosure to ation indicates
In accordance with s. 402.319(3), F. the provisions of s. 39.201, F.S., reg				
Jerry L. Demings , Appendix Ap	oplicant of <u>Southwood</u> connel are in complia	<u>d Head Start</u> nce with s. 39.201, F.S.	Chi	ild Care Facility, do
attest under penalty of perjury that all	ory requirements for b blicant of <u>Southwood</u> child care personnel	ackground screening. By s Head Start	signing belows Child Sare	
	MAR S	24 Ann 23 Date		
Background screening of owners, operators, and direct *Social security numbers are used for identification pur				COUNTY FLOR

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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.

ganization's Designated Representative Go Back Τo Person completing application if other than Owner or Organization's Designated Represent Name (please print): Title/Position/Relationship to the Owner: Telephone Number, including area code:

Do Not Write Below this Line – Official Use Only

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date Fee Forwarded to Fiscal Office:
Sexual Offender Addr (http://offender.fdle.sta		Date of Search:	Conducted by Signature/Initia	als: Exact Address Match:

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CF-FSP 5017, PDF 05/2019 [65C-22.001(1)(a), F.A.C.]





APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

MYFLEAMILIES.COM Press space bar (or left mouse click) to check a box; press space bar (or left mouse click) to uncheck a box. 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

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PART 1: PROGRA	AM INFORMATION	N (this section	must be co	mpleted in	its entirety)		
Application Type	Initial	*Renew	<i>i</i> al	Chang	e of [Revis	sion of
(choose one):	License	Year:	2022-23	Owner		Exist	ing License
Name of Facility as it is to				Telepho	ne Number		Phone Number:
John H. Bridges	Head Start				ng area code):)923-4033	(407)	254-9421
Street Address of Facility ((physical address):	City:			County:	Zip	Code:
445 West 13th S	street	Ap	oopka		Orange	e 3	2703
Mailing Address of Fac	cility, if different (include c	ity and zip code):					
2100 East Michig	gan Street, Orlan	do, FL 32806					
E-Mail Address:					FAX Numbe	er (including	g area code):
Wilna.Francois@	ocfl.net				(40	7)836-1	929
Is this facility located	in or	If yes	, all househol	d members m	nust be identif	ied, and	Maximum
adjacent to the home	of the Yes [No backg	round screen	ing complete	d. Please atta	ich a list	Capacity:
owner/operator?					nes and dates	of birth.	166
Days and Hours of (Operation – please	check AM or PM	W as applicab	ole:			
24 Hour Care							
Monday		Wednesday	Thursday	Friday	Saturd		Sunday
Opening A	M M AM	AM	AM	A	M	AM	AM
	PM 7:00 PM	7:00 PM 7	7:00 PM	7:00 P	M	PM	PM
	M AM	∐ AM	AM	A		AM	
Time: <u>6:00</u> P	м <u>6:00</u> Рм <u>6</u>	<u>6:00</u> ▶ PM <u>6</u>	:00 M	6:00 P	Μ	PM	PM
Months of Operatio	on: School Year Only	12 Months	Other:				
Program Designation	ons:						
Faith Based	Head Start	Urban Zone	Public/Non-	Public School		Scho	ol Readines
Check all service op	otions that apply:						
Full Day		Drop-In Nig	ht Care Be	fore School	After School	Wee	kend
Infant Ca	are (0-1) Food Se	1	sportation				
						11	



Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402.305(2), F.S.

PART 2: OWNERSHIP TYPE (check one)				
Individual Ownership - Not incorporated	Individual Owner	Complete Sections A and F		
Corporation	Corporation Documentation required	Complete Sections B and F		
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F		
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F		
Other Entity - Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F		

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security number:			
Home Address:	City:	State:	Zip Code:	
Telephone Number (including area code):				

SECTION B: CORPORATION (Special Instructions: Upon initial application for child care licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for child care licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:		Corporate and FEIN #:					
Address of Corporation:		Incorporated in which State?					
					n registered in o, please reg omitting an a	ister pri	ior to
City:	State:	Zip Code:	Teleph	one Number (including a	rea code):		
Designated Corporate Repres	sentative:			Date of Birth:		*Socia	al Security Number:
Home Address:			City:		State):):	Zip Code:

number for each member registered agent. Failu for revocation of this lic	les of Organiz ber of the Comp re to continuou ense. For REN	ation, which mu bany. Also attac sly maintain a n IEWAL applicat	(Special Instructions: ust include the names, the h the name and telephone egistered office and/or re- tions for child care licens e Department of State (a	ne title/office, add ne number of the egistered agent in ure, attach a curre	ress, and telephone corporation's n Florida is grounds ent copy of
Name of Company:	nuncale of Auth	orization from th	Company and FEIN #:	valiable through	SUNBIZ.Org).
Address of Company:			Organized in which Stat	e?	
			If out-of-state, is the con	npany registered in the If no, please regis submitting an ap	ster prior to
City:	State:	Zip Code:	Telephone Number (incl		
Designated Company Represe	entative:		Date of Birth:		*Social Security Number:
Home Address:			City:	State:	Zip Code:
Date of Birth:			*Social Security number	r:	
Home Address (street address	s):		City:	State:	Zip Code:
Telephone Number (including					
Partner #2 (First, Middle (Maio	den), Last):				
Date of Birth:			*Social Security number	r:	
Home Address (street address	5):		City:	State:	Zip Code:
Telephone Number (including	area code):				
SECTION E: OTHER operated by School Bo and other non-incorpor	ards or city/cou		RATED (Special Instr es, before and after sch	ructions: These a ool programs, fair	
Name of Entity:				<u> </u>	
Orange County, Flo Entity's Designated Represent		and/ or Maiden, Las	st):		
Address of Entity (street addre	ess):		City:	State	Zip Code:
201 South Rosaline			Orlando	FL	
Telephone Number (including	area code).				

(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.

SECTION F: ON-SITE DIRECTOR An On-site Director holds a Director O to be on-site for the majority of opera 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-Site ol programs for a sing	ble for the day-to-day opera Director holds a Director e organization as follows:	ation of the faci Credential and (a) Three sites	lity and is required supervises regardless of the
Wilna Francois				
Date of Birth:		*Social Security number:		
Home Address:		City:	State:	Zip Code:
586 Home Grove Drive		Winter Garden	FL	34787
Cell Phone Number (including area code): (407)923-4033	If applicable, name of Mult	i-Site Programs and enrollment:		
PART 3: ATTESTATION (To be	completed by all ap	plicants)		
Has the owner, applicant, or director the subject of a disciplinary action, or Yes You If yes, pleased	been fined while emp		/?	or jurisdiction, been
I hereby attest that the information con- Have you or anyone identified as a pa- with any state agency in any capacity Yes Mo If yes, when John H. Bridges Head Start,	arty to ownership ever other than a driver's l re, what type of license	held a license (child care, icense? e, license number, and unc	foster care, co	Initial smetology, etc.)
Pursuant to section 402.3054, F.S., upon screening, using level 2 standa provider, it is the responsibility of the accordingly, and parents/guardians p conducted by the child enrichment se	rds in Chapter 435, F director to ensure th provide written conse	S.S. If this facility utilizes at the child enrichment s	a child enrichi service provide	ment service er is screened
The Health Insurance Portability and information must be protected from of the public and to otherwise assure the that you agree to comply with the red children's health records in your pos	disclosure and maintane privacy of such info quirements of HIPAA	ined in a manner to prev prmation. Your signature	ent inadverter on this applic	it disclosure to ation 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 requestion of the requestion of the second second second second second second second second s Second second	irements of a mandated	reporter. By	vit of compliance signing below, I, ild Care Facility,
attest under penalty of perjury that all Buyers By By Signature of Applicant	ory requirements for b blicant <u>of John H. Bri</u> child care personnel	ackground screening. By s dges Head Start are in compliance with th 24 A M 23 Date	signing below Child Care e provisions of 	Eacility, do the by
Background screening of owners, operators, and direct *Social security numbers are used for identification pur	ctors who by definition are child poses when performing the bac	care personnel is required by s. 402 . kground screening required by ss. 40	.305(2), F.S.	STINTY FLO

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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.

Organization's Designated Representative Go Back To 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

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date Fee Forwarded to Fiscal Office:
Sexual Offender Addre (http://offender.fdle.sta		Date of Search:	Conducted by Signature/Initial	s: Exact Address Match:





BCC Mtg. Date: January 24, 2023



APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

MYFLEAMILIES.COM Press space bar (or left mouse click) to check a box; press space bar (or left mouse click) to uncheck a box. 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

FOR LICENSE RENEWALS ONLY: Renewal of this license is contingent upon the payment of any fines previously imposed as a sanction against this license that were not contested, or that were affirmed at an administrative hearing. If, at the time of this license renewal application, there is a pending administrative hearing resulting from a proposed fine, it shall not affect the renewal of this license.

adjacent to the home of the Yes No background screening completed. Please attach a list of family members with their names and dates of birth. Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening AM AM AM AM AM	PART 1: PROGRA	M INFORMATIO	N (this sec	tion must be co	ompleted in	its entirety)		
(choose one): License Year: 2022-23 Ownership Existing License Name of Facility as it is to appear on license: Telephone Number (including area code): Atternate Phone Number (including area code): Atternate Phone Number (including area code): Atternate Phone Number (including area code): Street Address of Facility (physical address): City: County: Zip Code: 101 North Parramore Street Orlando Orange 32805 Mailing Address of Facility, if different (include city and zip code): 2100 East Michigan Street, Orlando, FL 32806 FAX Number (including area code): 2100 East Michigan Street, Orlando, FL 32806 FAX Number (including area code): (407)836-2877 Is this facility located in or adjacent to the home of the Yes No background screening completed. Please attach a list of family members with their names and dates of birth. Capacity 62 Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Yeaday Wednesday Thursday Friday Saturday Sunday Opening AM AM AM AM AM AM AM AM AM Closing AM AM AM AM AM <td>Application Type</td> <td>Initial</td> <td>▼*Re</td> <td>newal</td> <td>Change</td> <td>e of</td> <td>Revis</td> <td>sion of</td>	Application Type	Initial	▼*Re	newal	Change	e of	Revis	sion of
Name of Facility as it is to appear on license: Telephone Number (including area code): Alternate Phone Number (including area code): Street Address of Facility (physical address): City: Orlando Orange 32805 Mailing Address of Facility. (physical address): Orlando Orange 32805 Mailing Address of Facility. if different (include city and zip code): 2100 East Michigan Street, Orlando, FL 32806 FAX Number (including area code): E-Mail Address: FAX Number (including area code): (407)836-2877 Toinett. Stenson@ocfl.net If yes, all household members must be identified, and background screening completed. Please attach a list of family members with their names and dates of birth. Maximur Capacity 62 Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Yuesday Wednesday Thursday Friday Saturday Sunday Opening AM AM AM AM AM AM AM AM AM Closing AM AM AM AM AM AM AM AM AM Closing AM	(choose one):	License	Yea	ar: 2022-23			Exist	ing License
Callahan Head Start (321)442-5181 (407)254-1926 Street Address of Facility (physical address): City: County: Zip Code: 101 North Parramore Street Orlando Orange 32805 Mailing Address of Facility, if different (include city and zip code): 2100 East Michigan Street, Orlando, FL 32806 FAX Number (including area code): E-Mail Address: FAX Number (including area code): (407)836-2877 Is this facility located in or adjacent to the home of the Yes No If yes, all household members must be identified, and background screening completed. Please attach a list of family members with their names and dates of birth. Maximur Capacity, 62 Days and Hours of Operation – please check AM or PM as applicable:	Name of Facility as it is to	appear on license:	-		Telepho	ne Number		
101 North Parramore Street Orlando Orange 32805 Mailing Address of Facility, if different (include city and zip code): 2100 East Michigan Street, Orlando, FL 32806 E-Mail Address: FAX Number (including area code): (407)836-2877 Is this facility located in or adjacent to the home of the Yes No If yes, all household members must be identified, and background screening completed. Please attach a list of family members with their names and dates of birth. Maximur Capacity, 62 Days and Hours of Operation – please check AM or PM as applicable:	Callahan Head S	Start				•	(407)	254-1928
Mailing Address of Facility, if different (include city and zip code): 2100 East Michigan Street, Orlando, FL 32806 E-Mail Address: FAX Number (including area code): Toinett. Stenson@ocfl.net (407)836-2877 Is this facility located in or If yes, all household members must be identified, and background screening completed. Please attach a list of family members with their names and dates of birth. Maximur Capacity 62 Days and Hours of Operation – please check AM or PM as applicable:	Street Address of Facility (physical address):		City:		County:	Zip	o Code:
2100 East Michigan Street, Orlando, FL 32806 FAX Number (including area code): (407)836-2877 Is this facility located in or adjacent to the home of the Yes No owner/operator? Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Monday Tuesday Wednesday Thursday Friday Saturday Sunday Yes Opening AM Time: 7:00 PM 7:00 PM 6:00 PM 0 Program Designations: 12 Months	101 North Parra	nore Street		Orlando		Orange	e 3	2805
E-Mail Address: FAX Number (including area code): Toinett.Stenson@ocfl.net (407)836-2877 Is this facility located in or If yes, all household members must be identified, and background screening completed. Please attach a list of family members with their names and dates of birth. Maximur Capacity 62 Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening MAM AM YAM AM AM AM AM AM AM Closing AM Months of Operation: School PM 6:00 PM 6:00 PM PM PM PM Program Designations: Year Only 12 Months Other: Program Designations: Program Designations: Program Designations:	Mailing Address of Fac	ility, if different (include c	tity and zip code	e):			I	
Toinett. Stenson@ocfl.net (407)836-2877 Is this facility located in or adjacent to the home of the Yes No owner/operator? If yes, all household members must be identified, and background screening completed. Please attach a list of family members with their names and dates of birth. Maximur Capacity 62 Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Saturday Sunday Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening AM AM AM AM AM AM AM Closing AM AM AM AM AM AM AM AM Months of Operation: School PM 6:00 PM 6:00 PM PM PM Program Designations: Program Designations: Program Designations: Program Designations: Program Designations:	2100 East Michig	gan Street, Orlan	do, FL 328	306				
Is this facility located in or adjacent to the home of the Yes No owner/operator? Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening AM AM AM AM AM AM AM Time: 7:00 PM 7:00 PM 7:00 PM 7:00 PM 7:00 PM PM Closing AM AM AM AM AM AM Closing AM AM AM AM Time: 6:00 PM 6:00 PM 6:00 PM 6:00 PM 6:00 PM Months of Operation: School 12 Months Other: Year Only	E-Mail Address:			د		FAX Numbe	er (including	g area code):
adjacent to the home of the Yes No background screening completed. Please attach a list of family members with their names and dates of birth. Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Monday Tuesday Wednesday Thursday Friday Saturday Sunday Monday Tuesday Wednesday Thursday Friday Saturday Sunday Monday Tuesday Wednesday Thursday Friday AM AM AM AM Opening AM YAM YAM YAM AM Closing AM AM Closing AM Closing AM Closing Cion PM Closing Cion	Toinett.Stenson(@ocfl.net				(40	7)836-2	877
adjacent to the home of the Yes No background screening completed. Please attach a list of family members with their names and dates of birth. 62 Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening AM Closing AM Closing Closing Completed. PM 6:00 PM 6:00 PM 6:00 PM 6:00 PM PM PM Months of Operation: School Yem 6:00 PM 6:00 Cher: Year Only Program Designations:	Is this facility located	in or	lf	yes, all househo	ld members m	ust be identif	ied, and	Maximum
Days and Hours of Operation – please check AM or PM as applicable: 24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening AM AM AM AM AM AM AM Time: 7:00 PM 7:00 PM 7:00 PM PM PM Closing AM AM AM AM AM AM AM AM Closing AM AM AM AM AM AM AM AM AM Months of Operation: School PM 6:00 PM 6:00 PM PM Program Designations: Year Only 12 Months Other:		of the Yes [No b	ackground screer	ning completed	d. Please atta	ich a list	Capacity: 62
24 Hour Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Opening AM A		Operation – please				ies and dates	or birth.	
Check all service options that apply: Full Day Half Day Drop-In Night Care Before School After School Weekend Infant Care (0-1) Food Served Transportation	Opening Time: 7:00 P Closing Time: 6:00 P Months of Operation Program Designation Faith Based Check all service op Full Day	M AM M 7:00 PM M AM M 6:00 PM m: School Year Only ns: Head Start Head Start Head Start Head Start Half Day re (0-1) Food Second	Image: Align of Align	M AM M 7:00 AM M AM AM A AM A AM A AM A AM A AM A	▼ A _7:00 P □ AI 6:00 ▼ P	M M M M	AM PM AM PM	AM PM AM PM



PART 2: OWNERSHIP TYPE (check one)				
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F		
Corporation	Corporation Documentation required	Complete Sections B and F		
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F		
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F		
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F		

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security numb	*Social Security number:			
Home Address:	City:	State:	Zip Code:		
Telephone Number (including area code):					

SECTION B: CORPORATION (Special Instructions: Upon initial application for child care licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for child care licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:			Corporate and FEIN #:			
Address of Corporation:		Incorporated in which State?				
					n registered in o, please reg omitting an a	ister prior to
City:	State:	Zip Code:	Telephone Number (including area code):			
Designated Corporate Re	epresentative:			Date of Birth:		*Social Security Number:
Home Address:			City:		State	e: Zip Code:

licensure, attach number for each registered agent. for revocation of t	Articles of Organiz member of the Comp Failure to continuou his license. For REN	ation, which mu bany. Also attac sly maintain a re I EWAL applicat	(Special Instructions: Up ist include the names, the h the name and telephone egistered office and/or regi ions for child care licensure e Department of State (avai	itle/office, addres number of the con stered agent in Fl a, attach a current	s, and telephone rporation's orida is grounds copy of
Name of Company:			Company and FEIN #:	di la casa da c	
Address of Company:			Organized in which State?		
			If out-of-state, is the compa	ny registered in the Sta If no, please register submitting an applic	prior to
City:	State:	Zip Code:	Telephone Number (includi	ng area code):	
Designated Company	Representative:		Date of Birth:	*So	cial Security Number:
Home Address:			City:	State:	Zip Code:
Partner #1 (First, Midd Date of Birth: Home Address (street Telephone Number (in Partner #2 (First, Midd	address): cluding area code):		*Social Security number: City:	State:	Zip Code:
Date of Birth:			*Social Security number:		
Home Address (street	address):		City:	State:	Zip Code:
Telephone Number (in	cluding area code):				
operated by Scho			RATED (Special Instructers, before and after school		
Orange Count	ty, Florida presentative (First, Middle	and/ or Maidan La	••1•		
		and/ or walden, Las	DL).		
Address of Entity (stree		-	City:	State:	Zip Code:
201 South Ro	salind Avenue		Orlando	FL	32801

Telephone Number (including area code):

(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.

SECTION F: ON-SITE DIRECTOR INFORMATION An On-site Director holds a Director Credential, is respons to be on-site for the majority of operating hours. A Multi-S multiple before-school and after-school programs for a sin number of children enrolled; or, (b) More than three sites Name (First, Middle and/or Maiden, Last):	sible for the day-to-day ite Director holds a Dir igle organization as fo	y operation of the fac rector Credential and llows: (a) Three site	cility and is required d supervises s regardless of the
Toinett Stenson			
Date of Birth:	*Social Security numb	er:	
Home Address:	City:	State:	Zip Code:
2633 Breezewind Drive	Orlando	FL	32839
Cell Phone Number (including area code): If applicable, name of M (321)442-5181	ulti-Site Programs and enro	Ilment:	
PART 3: ATTESTATION (To be completed by all a Has the owner, applicant, or director ever had a license d the subject of a disciplinary action, or been fined while err	enied, revoked, or sus	pended in any state facility?	or jurisdiction, been
Yes No If yes, please explain (attach ad		.,	perjury. <u>T. S.</u>
Have you or anyone identified as a party to ownership even with any state agency in any capacity other than a driver's Yes No If yes, where, what type of licen Callahan Head Start Certificate Number: C09	s license? se, license number, a		
Pursuant to section 402.3054, F.S., child enrichment se upon screening, using level 2 standards in Chapter 435 provider, it is the responsibility of the director to ensure accordingly, and parents/guardians provide written con- by the child enrichment service provider.	, F.S. If this facility ut that the child enrichr	ilizes a child enrich ment service provid	nment service ler is screened
The Health Insurance Portability and Accountability Act information must be protected from disclosure and main public and to otherwise assure the privacy of such infor- you agree to comply with the requirements of HIPAA by health records in your possession.	itained in a manner to mation. Your signatu	prevent inadverte re on this application	nt disclosure to the on indicates that
In accordance with s. 402.319(3), F.S., each childcare the provisions of s. 39.201, F.S., regarding the requirem			
<u>Jerry L. Demings</u> , Applicant of <u>Callahar</u> hereby affirm that all child care personnel are in compl Pursuant to section 435.05(3), F.S., each employer must att	iance with s. 39.201,	F.S.	hild Care Facility, do
Additional and the statutory requirements for backgro Jerry L, Demings , Applicant of <u>Callahan</u> attest under penalty of perjury that all child care personne Signature of Applicant Background screening of owners, operators, and directors who by definition are ch *Social security numbers are used for identification purposes when performing the t	und screening. By sign Head Start el are in compliance v 	ning below, I Child Ser with the provisions of 23 y s. 402 .305(2), F.S.	Chapter 20, his

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

	By Bubb Signature of Owner or Organization's Designated Representative	123 NUNIY COM
	Gol	Back To Page 2
Person	completing application if other than Owner or Organization's Designated R Name (please print):	epresentative
	Title/Position/Relationship to the Owner:	
	Telephone Number, including area code:]

Do Not Write Below this Line – Official Use Only

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date Fee Forwarded to Fiscal Office:
Sexual Offender Addre (http://offender.fdle.sta		Date of Search:	Conducted by Signature/Initials	Exact Address Match:





APPLICATION FOR A LICENSE TO OPERATE A CHILD CARE FACILITY

APPROVED BY ORANGE COUNTY BOARD OF COUNTY COMMISSIONERS

BCC Mtg. Date: January 24, 2023

PLEASE TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK

MYFLFAMILIES.COM Press space bar (or left mouse click) to check a box; press space bar (or left mouse click) to uncheck a box. 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

FOR LICENSE RENEWALS ONLY: Renewal of this license is contingent upon the payment of any fines previously imposed as a sanction against this license that were not contested, or that were affirmed at an administrative hearing. If, at the time of this license renewal application, there is a pending administrative hearing resulting from a proposed fine, it shall not affect the renewal of this license.

PART 1: PROGRAM INFORMATIC	ON (this section must be co	mpleted in its entir	ety)
Application Type	*Renewal	Change of	Revision of
(choose one): License	Year: 2022-23	Ownership	Existing License
Name of Facility as it is to appear on license:		Telephone Number (including area cod	
Washington Shores Early Learn	ing Center Head Start	(321)895-02	
Street Address of Facility (physical address):	City:	County:	Zip Code:
2500 Bruton Boulevard	Orlando	Ora	ange 32811
Mailing Address of Facility, if different (include	e city and zip code):		
2100 East Michigan Street, Orla	indo, FL 32806		
E-Mail Address:		FAX	Number (including area code):
Aturia.Hall@ocfl.net			(407)836-1926
Is this facility located in or		d members must be id	
adjacent to the home of the Yes		ing completed. Please	
owner/operator? Days and Hours of Operation – pleas		with their names and d	ates of birth.
Check all service options that apply: Full Day Half Day	AM AM <u>6:00</u> PM <u>6:00</u> PM 12 Months Other: Urban Zone Public/Non-	▲ AM 7:00 □ PM △ AM 6:00 ✔ PM	_



Background screening of owners, operators, and directors who by definition are child care personnel is required by s. 402 .305(2), F.S.

PART 2: OWNERSHIP TYPE (check one)						
Individual Ownership – Not incorporated	Individual Owner	Complete Sections A and F				
Corporation	Corporation Documentation required	Complete Sections B and F				
Limited Liability Company (LLC)	LLC Documentation required	Complete Sections C and F				
Partnership – Not Incorporated	Partnership Documentation required	Complete Sections D and F				
Other Entity – Not Incorporated	e.g., School Board, Local Government, Before & After School Programs, Parks and Recreation, Faith Based	Complete Sections E and F				

SECTION A: INDIVIDUAL OWNERSHIP - NOT INCORPORATED (Special Instructions: One owner)

Name (First, Middle and/or Maiden, Last):

Date of Birth:	*Social Security numb		
Home Address:	City:	State:	Zip Code:
Telephone Number (including area code):			

SECTION B: CORPORATION (Special Instructions: Upon initial application for child care licensure, attach Articles of Incorporation, which must include the names, the title/office, address, and telephone number for each member of the Board of Directors. Also attach the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or registered agent in Florida is grounds for revocation of this license. For **RENEWAL applications** for child care licensure, attach a current copy of Certificate of Status/Certificate of Authorization from the Department of State (available through SunBiz.org).

Name of Corporation:		Corporate and FEIN #:				
Address of Corporation:		Incorporated in which State?				
			In If n	o, please reg	ister pri	ior to
State:	Zip Code:	Telephone Number (including area code):				
sentative:			Date of Birth:		*Socia	al Security Number:
		City:		State) e:	Zip Code:
			Incorpo If out-o State: Zip Code: Teleph sentative:	Incorporated in which State?	Incorporated in which State? If out-of-state, is the corporation registered in If no, please reg State: Zip Code: Telephone Number (including area code): sentative: Date of Birth:	Incorporated in which State? If out-of-state, is the corporation registered in the St Yes No State: Zip Code: Telephone Number (including area code): sentative: Date of Birth:

SECTION C: LIMITED LIA licensure, attach Articles of number for each member of t registered agent. Failure to co for revocation of this license. Certificate of Status/Certificate	Organiza he Comp ontinuous For REN	ation, which mus any. Also attach sly maintain a re EWAL application	st include to the name gistered o ons for chi	he names, the title and telephone nu ffice and/or registe d care licensure, a	e/office, add mber of the red agent in ttach a curre	corporation's Florida is grounds ent copy of
Name of Company:				ny and FEIN #:		
Address of Company:			Organi	red in which State?		
				es No su	no, please regis bmitting an a	ster prior to
City:	State:	Zip Code:	Teleph	one Number (including	area code):	
Designated Company Representative:				Date of Birth:		*Social Security Number:
Home Address:			City:	1	State:	Zip Code:
Partnership Agreement annu Partner #1 (First, Middle (Maiden), Las Date of Birth:		ch additional she		Security number:	in two partr	iers.)
Home Address (street address):			City:		State:	Zip Code:
Telephone Number (including area co	de):					
Partner #2 (First, Middle (Maiden), Las	st):					
Date of Birth:			*Socia	Security number:		
Home Address (street address):			City:		State	Zip Code:
Telephone Number (including area con	de):					
SECTION E: OTHER ENT operated by School Boards of and other non-incorporated en Name of Entity: Orange County, Florida Entity's Designated Representative (F	entities.)	inty municipalitie	es, before			
Aturia D. Hall Address of Entity (street address):			City:		State	Zip Code:
201 South Rosalind Ave	nue			ando	FL	
Telephone Number (including area co (407)836-6590						

SECTION F: ON-SITE DIRECTOR IN An On-site Director holds a Director Cred to be on-site for the majority of operating multiple before-school and after-school pr number of children enrolled; or, (b) More Name (First, Middle and/or Maiden, Last): Aturia D. Hall	ential, is respons hours. A Multi-Sit rograms for a sing	ble for the day-to-day ope e Director holds a Directo gle organization as follows	eration of the faci r Credential and s: (a) Three sites	lity and is required supervises regardless of the		
Date of Birth:		*Social Security number:	· · ·			
Home Address:		City:	State:	Zip Code:		
4813 Skeena Street		Orlando	FL	32819		
Cell Phone Number (including area code): (321)895-0270						
PART 3: ATTESTATION (To be com	pleted by all a	policants)				
Has the owner, applicant, or director even the subject of a disciplinary action, or bee Yes Yes No If yes; please e	en fined while emp		ity?	or jurisdiction, been		
I hereby attest that the information contain Have you or anyone identified as a party with any state agency in any capacity oth Yes No If yes, where, w Washington Shores Early Learn	to ownership eve er than a driver's /hat type of licens	r held a license (child care license? e, license number, and ur	e, foster care, cos nder what name?	Initial smetology, etc.)		
Pursuant to section 402.3054, F.S., child upon screening, using level 2 standards provider, it is the responsibility of the dir accordingly, and parents/guardians prov conducted by the child enrichment service The Health Insurance Portability and Acc information must be protected from disc the public and to otherwise assure the p	in Chapter 435, ector to ensure t ide written cons ce provider. countability Act (osure and maint	F.S. If this facility utilize hat the child enrichment ent before a child may p (HIPAA) requires that pe ained in a manner to pre	s a child enrichr service provide articipate in acti rsonally identifi vent inadverten	nent service er is screened vities able health t disclosure to		
that you agree to comply with the require children's health records in your posses	ements of HIPAA sion.	by protecting the confic	lentiality of emp	loyee and		
In accordance with s. 402.319(3), F.S., with the provisions of s. 39.201, F.S., re Jerry L. Demings , Applic do hereby affirm that all child care person	egarding the req ant of <u>Washingt</u>	uirements of a mandate on Shores Early Learning	d reporter. By <u>g Center</u> Chi	signing below, I,		
Pursuant to section 435.05(3), F.S., each Chapter 435, F.S., regarding the statutory Jerry L. Demings, Applica hereby attest under penalty of perjury the Bignature of Applicant Background screening of owners, operators, and directors of *Social security numbers are used for identification purposes	requirements for to the second	background screening. By <u>n Shores Early Learning</u> bersonnel are in complia <u>24</u> Jenn 25 Date Date personnel is required by s. 40	2. 305(2), F.S.	COUNTY FLORING		

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.

ner or Organization's Designated Representative Go Back To Page 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

Date Fee Received:	Amount:	Check Number:	Received by Signature/Initials:	Date Fee Forwarded to Fiscal Office:
Sexual Offender Addre (http://offender.fdle.sta		Date of Search:	Conducted by Signature/Initia	als: Exact Address Match: