



Interoffice Memorandum

AGENDA ITEM

January 23, 2017

TO: Mayor Teresa Jacobs
and
Board of County Commissioners

THRU: Lonnie C. Bell, Jr., Director *Lonnie C. Bell*
Family Services Department

FROM: Sonya L. Hill, Manager *Sonya L. Hill*
Head Start Division
Contact: Khadija Pirzadeh, (407) 836-8912
Sonya Hill, (407) 836-7409

SUBJECT: Florida Department of Children and Families
Application for a License to Operate a Child Care Facility
BCC Meeting 2/21/17 Consent Agenda/District 6

The Head Start Division requests Board approval of the application for a renewal license between the Florida Department of Children and Families and Orange County. This license will allow the Head Start Program to provide comprehensive early childhood development for preschool children and support to their families at Southwood Head Start. The term of this license is from April 30, 2017 through April 30, 2018. The license fee of \$100 will be paid with Head Start funds.

This is a standard application for a license that is required by Florida Department of Children and Families for all licensed childcare facilities. The County Attorney's Office and Risk Management Division have reviewed this application in the past for Head Start Centers currently in operation.

ACTION REQUESTED: Approval and execution of Florida Department of Children and Families Application for a License to Operate a Child Care Facility at Southwood Head Start. This application is only executed by Orange County. (Head Start Division)

SH/kp

C: Randy Singh, Assistant County Administrator
Wanzo Galloway, Assistant County Attorney, County Attorney's Office
Yolanda S. Brown, Manager, Fiscal Division, Family Services Department
John Petrelli, Director, Risk Management and Professional Standards
Jamillem Clemens, Grants Supervisor, Finance Division
Patria Morales, Grants Coordinator, Office of Management & Budget

BCC Mtg. Date: February 21, 2017



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 was not contested, or that was 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.

| SECTION 1: PROGRAM INFORMATION (THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Application Type (Choose One): <input type="checkbox"/> Initial <input checked="" type="checkbox"/> *Renewal Year <u>2017</u> <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Revision of Existing License | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Facility as it is to appear on license: Southwood Head Start | | | | | | Telephone Number (including area code): (407) 254-6768 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | Alternate Telephone Number: () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Street Address of Facility (physical address): 6225 Brookgreen Avenue | | | | City: Orlando | County: Orange | Zip Code: 32809 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mailing Address of Facility, if different (include city and zip code): 2100 E. Michigan Street Orlando 32806 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E-Mail Address: Dina.Mathews@ocfl.net | | | | E-Mail: <input type="checkbox"/> Do Not Have E-Mail <input type="checkbox"/> Do Not Wish to Provide | | Fax Number (including area code): (407) 355-5770 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this facility located in or adjacent to the home of the owner/operator? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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. | | | Maximum Capacity: 127 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Days and Hours of Operation – please check AM or PM as applicable: <table style="width:100%; text-align: center;"> <thead> <tr> <th></th> <th>Monday</th> <th>Tuesday</th> <th>Wednesday</th> <th>Thursday</th> <th>Friday</th> <th>Saturday</th> <th>Sunday</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/> 24 hour care</td> <td><input checked="" type="checkbox"/> AM</td> <td><input checked="" type="checkbox"/> AM</td> <td><input checked="" type="checkbox"/> AM</td> <td><input checked="" type="checkbox"/> AM</td> <td><input checked="" type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> </tr> <tr> <td>Opening Time: 7:30</td> <td><input type="checkbox"/> PM</td> <td>7:30 <input type="checkbox"/> PM</td> <td>7:30 <input type="checkbox"/> PM</td> <td>7:30 <input type="checkbox"/> PM</td> <td>7:30 <input type="checkbox"/> PM</td> <td><input type="checkbox"/> PM</td> <td><input type="checkbox"/> PM</td> </tr> <tr> <td>Closing Time: 5:30</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> AM</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> PM</td> <td>5:30 <input checked="" type="checkbox"/> PM</td> <td>5:30 <input checked="" type="checkbox"/> PM</td> <td>5:30 <input checked="" type="checkbox"/> PM</td> <td>5:30 <input checked="" type="checkbox"/> PM</td> <td><input type="checkbox"/> PM</td> <td><input type="checkbox"/> PM</td> </tr> </tbody> </table> | | | | | | | | | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | <input checked="" type="checkbox"/> 24 hour care | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | Opening Time: 7:30 | <input type="checkbox"/> PM | 7:30 <input type="checkbox"/> PM | 7:30 <input type="checkbox"/> PM | 7:30 <input type="checkbox"/> PM | 7:30 <input type="checkbox"/> PM | <input type="checkbox"/> PM | <input type="checkbox"/> PM | Closing Time: 5:30 | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | | <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | <input type="checkbox"/> PM | <input type="checkbox"/> PM |
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| <input checked="" type="checkbox"/> 24 hour care | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input checked="" type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Closing Time: 5:30 | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | 5:30 <input checked="" type="checkbox"/> PM | <input type="checkbox"/> PM | <input type="checkbox"/> PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Months of Operation: <input type="checkbox"/> School Year Only <input checked="" type="checkbox"/> 12 months <input type="checkbox"/> Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Check all service options that apply: <table style="width:100%;"> <tr> <td>Full Day <input checked="" type="checkbox"/></td> <td>Half Day <input type="checkbox"/></td> <td>Drop-In <input type="checkbox"/></td> <td>Night Care <input type="checkbox"/></td> <td>Before School <input type="checkbox"/></td> </tr> <tr> <td>After School <input type="checkbox"/></td> <td>Weekend <input type="checkbox"/></td> <td>Infant Care (0-1) <input type="checkbox"/></td> <td>Food Served: <input checked="" type="checkbox"/></td> <td>Transportation <input type="checkbox"/></td> </tr> </table> | | | | | | Full Day <input checked="" type="checkbox"/> | Half Day <input type="checkbox"/> | Drop-In <input type="checkbox"/> | Night Care <input type="checkbox"/> | Before School <input type="checkbox"/> | After School <input type="checkbox"/> | Weekend <input type="checkbox"/> | Infant Care (0-1) <input type="checkbox"/> | Food Served: <input checked="" type="checkbox"/> | Transportation <input type="checkbox"/> | Program operated as a: (Check Only One) <input checked="" type="checkbox"/> Child Care Facility OR <input type="checkbox"/> School-Age Child Care Program | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full Day <input checked="" type="checkbox"/> | Half Day <input type="checkbox"/> | Drop-In <input type="checkbox"/> | Night Care <input type="checkbox"/> | Before School <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| After School <input type="checkbox"/> | Weekend <input type="checkbox"/> | Infant Care (0-1) <input type="checkbox"/> | Food Served: <input checked="" type="checkbox"/> | Transportation <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| SECTION 2: OWNERSHIP TYPE (CHECK ONE) | | |
|---|---|---------------------------|
| <input type="checkbox"/> Individual Ownership - Not incorporated | Individual Owner | Complete Sections A and E |
| <input type="checkbox"/> Corporation | Corporation Documentation required | Complete Sections B and E |
| <input type="checkbox"/> Partnership – Not Incorporated | Partnership Documentation required | Complete Sections C and E |
| <input checked="" type="checkbox"/> Other Entity – Not Incorporated Local Government | e.g. School Board, Local Government Before & After School programs, Parks and Recreation, Faith Based | Complete Sections D and E |

| 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? | | |
| | | | If out of state, is the corporation registered in the State of Florida? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please register prior to submitting an application. | | |
| City: | State: | Zip Code: | Telephone Number (including area code): () | | |
| Designated Corporate Representative: | | | Date of Birth: | | Social Security Number*: |
| Home Address: | | City: | State: | Zip Code: | |

SECTION C: PARTNERSHIP – NOT INCORPORATED (Special Instructions: Attach a copy of the Partnership Agreement annually. Attach additional sheets as applicable if more than two partners.)

| | | | |
|---|--|--------------------------|------------------|
| Partner #1 (First Middle (Maiden) Last): | | | |
| Date of Birth: | | Social Security Number*: | |
| Home Address (street address): | | City: | State: Zip Code: |
| Telephone Number (including area code): () | | | |
| Partner #2 (First Middle (Maiden) Last): | | | |
| Date of Birth: | | Social Security Number*: | |
| Home Address (street address): | | City: | State: Zip Code: |
| Telephone Number (including area code): () | | | |

SECTION D: OTHER ENTITY – NOT INCORPORATED (Special Instructions: These are programs operated by School Boards, before and after school programs, faith based programs and other non-incorporated entities.)

| | | | |
|---|--|------------------|------------------------------|
| Name of Entity: Orange County, Florida | | | |
| Entity's Designated Representative (First Middle and or Maiden Last): | | | |
| Address of Entity (Street Address): 201 S. Rosalind Avenue | | City: Orlando | State: Zip Code: FL 32801 |
| Telephone Number (including area code): (407) 836-6590 | | | |

SECTION E: ON-SITE DIRECTOR INFORMATION - To be completed by all applicants (Special Instructions: An On-site Director holds a Director Credential and is responsible for the day-to-day operation of the facility and is required to be on-site the majority of operating hours. A Multi-site Director holds a Director Credential and supervises multiple before-school and after-school programs for a single organization as follows: (a) Three sites regardless of the number of children enrolled or (b) More than three sites if the combined number of children does not exceed 350.)

| | | | |
|--|--|--|------------------|
| Name: (First Middle and or Maiden Last) | | | |
| Date of Birth: | | Social Security Number*: | |
| Home Address: | | City: | State: Zip Code: |
| Telephone Number (including area code): () | | If Applicable, Name of Multi-Site Programs and enrollment: | |

SECTION 3: ATTESTATION (To be completed by all applicants)

Has the owner, applicant, or director ever had a license denied, revoked, or suspended in any state or jurisdiction, been the subject of a disciplinary action, or been fined while employed in a child care facility?
☐ Yes ☒ No If yes, please explain: (attach additional sheet(s) if necessary)

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? FL Child Care Facility
License Certificate No. C090R0251

Pursuant to section 402.3054, F.S., child enrichment service providers shall be of good moral character based upon screening, using level 2 standards in Chapter 435, F.S. If this facility utilizes a child enrichment service provider, it is the responsibility of the director to ensure that the child enrichment service provider is screened accordingly and parents/guardians provide written consent before a child may participate in activities conducted by the child enrichment service provider.

The Health Insurance Portability and Accountability Act (HIPAA) requires that personally identifiable health information must be protected from disclosure and maintained in a manner to prevent inadvertent disclosure to the public and to otherwise assure the privacy of such information. Your signature on this application indicates that you agree to comply with the requirements of HIPAA by protecting the confidentiality of employee and children's health records in your possession.

Pursuant to section 435.05(3), F.S., each employer must attest via signed affidavit compliance the provisions of Chapter 435.04, F.S. By signing below, I Teresa Jacobs, Applicant of Southwood Head Start Child Care Facility, do hereby affirm that all child care personnel meet the statutory requirements for background screening.

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.

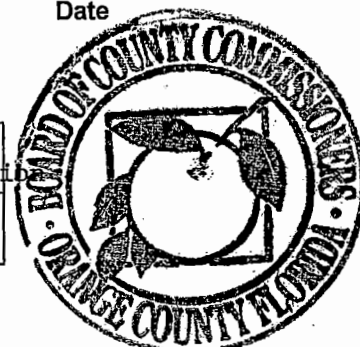
Teresa Jacobs
Signature of Owner or Organization's Designated Representative
Teresa Jacobs, Orange County Mayor

2.21.17

Date

Person completing application if other than Owner or Organization's Designated Representative.

| |
|---|
| Name: (Please Print) |
| Khadija Pirzadeh, Contract Administrator, Head Start Division |
| Telephone number including area code: |
| (407) 836-8912 |



Sworn to and subscribed before me this 21 day of February, 2017.

Craig A. Stopyra
SIGNATURE OF NOTARY PUBLIC, STATE OF FLORIDA

Craig A. Stopyra
(Print, Type, or Stamp Commissioned Name of Notary Public)



CRAIG A. STOPYRA
MY COMMISSION # FF 199641
EXPIRES: February 15, 2019
Bonded Thru Budget Notary Services

(Check one)

☒ Affiant personally known to notary

OR

☐ Affiant produced identification

Type of identification produced: _____

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 Address Cross Reference (http://offender.fde.state.fl.us) | Date of Search | Conducted by Signature/Initials | Exact Address Match | |
| | | | <input type="checkbox"/> Yes | |
| | | | <input checked="" type="checkbox"/> No | |