Interoffice Memorandum

ORANGE COUNTY GOVERNMENT FLORIDA

AGENDA ITEM

January 9, 2018

TO: Mayor Teresa Jacobs
and
Board of County Commissioners

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

FROM: Sonya L. Hill, Manager
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 2/6/18 Consent Agenda/District 6

The Head Start Division requests Board approval of a renewal license between 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 Lila Mitchell Head Start. The effective date of this license is from April 10, 2018 through April 10, 2019. The license fee of $100 will be paid with Head Start funds.

This is a standard application for a license that is required by the Florida Department of Children and Families for all licensed child care 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 Lila Mitchell Head Start. This application is only executed by Orange County. (Head Start Division)**

SH/kp
C: Randy Singh, Assistant County Administrator
Cristina Berrios, Assistant County Attorney, County Attorney's Office
John Petrelli, Director, Risk Management and Professional Standards
Yolanda Brown, Manager, Fiscal Division, Family Services Department
Jamille Clemens, Grants Supervisor, Finance Division
Patria Morales, Grants Coordinator, Office of Management & Budget

APPROVED BY ORANGE
COUNTY BOARD OF COUNTY
COMMISSIONERS

BCC Mtg. Date: February 6, 2018

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)

Application Type (Choose One): ☐ Initial ☒ *Renewal Year 2018 ☐ Change of Ownership ☐ Revision of Existing License

Name of Facility as it is to appear on license:	Telephone Number (including area code):
Lila Mitchell Head Start	407) 254-9494
	Alternate Telephone Number: ( )

Street Address of Facility (physical address):	City:	County:	Zip Code:
5151 Raleigh Street	Orlando	Orange	32811

Mailing Address of Facility, if different (include city and zip code):		
2100 East Michigan Street	Orlando	32806

E-Mail Address:	E-Mail:	Fax Number (including area code):
John.Holmes@ocfl.net	☐ Do Not Have E-Mail ☐ Do Not Wish to Provide	(407) 836-1930

Is this facility located in or adjacent to the home of the owner/operator? ☐ 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.	Maximum Capacity: 135

Days and Hours of Operation – please check AM or PM as applicable:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
☒ 24 hour care							
Opening Time:	7:30 ☒AM ☐PM	7:30 ☒AM ☐PM	7:30 ☒AM ☐PM	7:30 ☒AM ☐PM	7:30 ☒AM ☐PM	____ ☐AM ☐PM	____ ☐AM ☐PM
Closing Time:	5:30 ☐AM ☒PM	5:30 ☐AM ☒PM	5:30 ☐AM ☒PM	5:30 ☐AM ☒PM	5:30 ☐AM ☒PM	____ ☐AM ☐PM	____ ☐AM ☐PM

Months of Operation: ☐ School Year Only ☒ 12 months ☐ Other

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
☐	☐	☐	☒	☐

Program operated as a:
(Check Only One)
☒ Child Care Facility
OR
☐ School-Age Child Care Program

SECTION 2: OWNERSHIP TYPE (CHECK ONE)

☐ Individual Ownership - Not incorporated	Individual Owner	Complete Sections **A and E**
☐ Corporation	Corporation Documentation required	Complete Sections **B and E**
☐ Partnership – Not Incorporated	Partnership Documentation required	Complete Sections **C and E**
☒ 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): ( )			

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

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 ☐ No ☐ 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: FL	Zip Code: 32801
Telephone Number (including area code): (407) 836-6590			

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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? Child Care Facility Certificate of License, No. C09OR0234, Lila Mitchell Head Start

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 Lila Mitchell 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.

B.J Jacobs — FEB 06 2018

Signature of Owner or Organization's Designated Representative — Date

Teresa Jacobs, Orange County Mayor

for

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

BOARD OF COUNTY COMMISSIONERS • ORANGE COUNTY FLORIDA

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Sworn to and subscribed before me this ____ day of FEB 06 2018.

Noelia Perez
SIGNATURE OF NOTARY PUBLIC, STATE OF FLORIDA

Noelia Perez
(Print, Type, or Stamp Commissioned Name of Notary Public)

NOTARY PUBLIC STATE OF FLORIDA
NOELIA PEREZ
MY COMMISSION # FF 221795
EXPIRES: April 19, 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.fdle.state.fl.us)	Date of Search	Conducted by Signature/Initials	Exact Address Match ☐ Yes ☐ No

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