



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION  
**APPLICATION FOR LICENSE TO OPERATE  
CHILD CARE HOME**

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**IDENTIFYING INFORMATION**

NAME OF FACILITY		<input type="checkbox"/> APPLICANT'S RESIDENCE	<input type="checkbox"/> INITIAL
		<input type="checkbox"/> OTHER LOCATION	<input type="checkbox"/> RENEWAL
LOCATION (STREET, CITY, STATE, ZIP CODE)		FACILITY TELEPHONE (     )	
MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE)		COUNTY	
DIRECTIONS TO FACILITY:		E-MAIL ADDRESS	
ARE YOU CURRENTLY LICENSED BY ANY OTHER STATE AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO    IF YES, EXPLAIN:			

**LICENSE SPECIFICATIONS REQUESTED**

CAPACITY	AGE RANGE OF CHILDREN  _____ THROUGH _____	HOURS OF OPERATION 6:00 A.M. – 9:00 P.M. (DAYTIME) <input type="checkbox"/> 9:00 P.M. – 6:00 A.M. (NIGHTTIME) <input type="checkbox"/> 6:00 A.M. – 6:00 A.M. (24 HOUR CARE) <input type="checkbox"/>	DAYS OF OPERATION (CHECK APPROPRIATE BOXES.) <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THURS <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN
MONTHS OF OPERATION: (CHECK ANY THAT APPLY)			
<input type="checkbox"/> ALL 12 MONTHS <input type="checkbox"/> JAN <input type="checkbox"/> FEB <input type="checkbox"/> MARCH <input type="checkbox"/> APRIL <input type="checkbox"/> MAY <input type="checkbox"/> JUNE <input type="checkbox"/> JULY <input type="checkbox"/> AUG <input type="checkbox"/> SEPT <input type="checkbox"/> OCT <input type="checkbox"/> NOV <input type="checkbox"/> DEC			

**ADMINISTRATION**

**LIST NAME(S) OF OWNER(S), ORGANIZATION OR CORPORATION OPERATING CHILD CARE FACILITY (Attach additional pages as needed.)**

NAME \_\_\_\_\_

ADDRESS (STREET, CITY, STATE, ZIP CODE) \_\_\_\_\_ TELEPHONE NUMBER (     ) \_\_\_\_\_

**INCORPORATED OR OTHER LEGAL IDENTITY REGISTERED WITH OFFICE OF SECRETARY OF STATE  YES  NO**

**DATE OF INCORPORATION:** \_\_\_\_\_

**IF INCORPORATED, LIST NAME OF BOARD PRESIDENT OR CHAIRPERSON.**

NAME \_\_\_\_\_

ADDRESS (STREET, CITY, STATE, ZIP CODE) \_\_\_\_\_ TELEPHONE NUMBER (     ) \_\_\_\_\_

**IF INCORPORATED, LIST NAME OF CHILD CARE HOME PROVIDER.**

NAME \_\_\_\_\_

ADDRESS (STREET, CITY, STATE, ZIP CODE) \_\_\_\_\_ TELEPHONE NUMBER (     ) \_\_\_\_\_

**PHYSICAL PLANT**

FLOOR(S) FOR CHILD CARE Check all that apply <input type="checkbox"/> BASEMENT <input type="checkbox"/> 1 <sup>ST</sup> FLOOR <input type="checkbox"/> 2 <sup>ND</sup> FLOOR <input type="checkbox"/> OTHER	WATER SYSTEM <input type="checkbox"/> PUBLIC <input type="checkbox"/> PRIVATE <input type="checkbox"/> OTHER
SOURCE AND TYPE OF HEATING SYSTEM	SEWAGE DISPOSAL SYSTEM <input type="checkbox"/> PUBLIC <input type="checkbox"/> PRIVATE <input type="checkbox"/> OTHER

**PLEASE READ INFORMATION BELOW BEFORE SIGNING APPLICATION.**

The undersigned is the person(s) named as applicant(s). The information given is true and accurate. I/we have read Section 210.201-210.259 RSMo 2000 and the licensing rules for child care homes in Missouri. I/we understand that:

A. A license will be granted when facility has been determined in compliance with state statutes and licensing rules.  
B. If rules are not met within six months of the filing date, this application shall be void.  
C. The license is not transferable and applies only to the person(s) and address shown on the license.  
D. The license may be subject to revocation or other disciplinary actions for failure to maintain compliance with state statutes and licensing rules.  
E. The licensing record is open to the public for review, if requested.  
F. I/we agree to accept and provide care to children without regard to race, sex, religion, national origin or disability.  
G. I/we, other adult household members, other child care staff, and board president or chairperson who have contact with the children in care must be screened through the Family Care Safety Registry.  
H. The applicant is responsible for compliance with local zoning regulations pertaining to this facility.

**THE UNDERSIGNED IS THE PERSON(S) RESPONSIBLE FOR THE INFORMATION GIVEN AND STATES THE INFORMATION IS TRUE AND ACCURATE.**

SIGNATURE OF OWNER(S)/ BOARD CHAIRPERSON/ DESIGNEE (CIRCLE APPROPRIATE TITLE)	DATE
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