



**SCHOOL READINESS CHILD CARE PROVIDER
INTENT TO CONTRACT
2010-2011**

Please complete this form in order to assist us to effectively assess your program.

By signing this document, you are stating you are authorized to enter an Intent to Contract with the Early Learning Coalition of Lake County (ELCLC) and ELCLC Contracted Agency.

By completing, returning and signing this form, you are notifying the ELCLC and ELCLC Contracted Agency of your intent to enter into a contract to provide School Readiness services and to allow staff of the Early Learning Coalition to enter your program and conduct assessments, technical assistance, child screenings, and other evaluations related to child care services.

Please return Intent to Contract with a copy of your DCF License, Registration letter or Religious Exempt Certificate as well as a copy of your Certificate of Liability Insurance form. All incomplete forms will be returned and the Intent to Contract will not be valid.

Provider Information:

Name of Provider/Owner: _____

Name of Center (if applicable): _____

Center Address: _____

Center Phone: _____

Center Fax: _____

Email: _____

DCF License #: _____

Registration #: _____

Hours of Service: _____

Days Per Week of Service: _____

Out of County: Yes No

Name of County: _____

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Classroom Information: Please list how many classrooms you have in each age group and what the current number of enrolled children is at this time.

Age Group		# of Classrooms	Children Enrolled	Curriculum
Infants	(0-12 months)	_____	_____	_____
Toddlers	(13-23 months)	_____	_____	_____
Twos	(24-35 months)	_____	_____	_____
Threes	(36-48 months)	_____	_____	_____
Fours	(48-60 months)	_____	_____	_____
School Age	(attends school)	_____	_____	_____

Contact Information:

Center Owner/Director/Representative: (Please list all applicable names)

Alternate Contact: (Designated as acting manager in owner/director absence)

Miscellaneous: Is there anything you need us to know about your program?

Printed Name of Authorized Person Completing This Form:

Signature of Authorized Person Completing This Form:

Date:

For internal use only:

Completed Provider Orientation: Yes No N/A Date Attended: _____ Staff Initials: _____

ERS Assessment(s) or Evaluation completed:

<input type="checkbox"/> ITERS	<input type="checkbox"/> ECERS	<input type="checkbox"/> FCCERS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Score: _____	<input type="checkbox"/> Passed <input type="checkbox"/> Failed
<input type="checkbox"/> ITERS	<input type="checkbox"/> ECERS	<input type="checkbox"/> FCCERS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Score: _____	<input type="checkbox"/> Passed <input type="checkbox"/> Failed
<input type="checkbox"/> ITERS	<input type="checkbox"/> ECERS	<input type="checkbox"/> FCCERS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Score: _____	<input type="checkbox"/> Passed <input type="checkbox"/> Failed
<input type="checkbox"/> Health & Safety Check			<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Score: _____	<input type="checkbox"/> Passed <input type="checkbox"/> Failed

Coalition Staff Signature: _____

Date Approved: _____

