

APPENDIX I



**SCHOOL READINESS CHILD CARE PROVIDER  
INTENT TO CONTRACT  
2011-2012**

**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. If you are currently serving children under a School Readiness Contract, you only need to return the Intent to Contract.**

**Provider Information:**

Name of Provider/Owner: \_\_\_\_\_

Name of Center (if applicable): \_\_\_\_\_

Center Address: \_\_\_\_\_

Center Phone: \_\_\_\_\_

Center Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

DCF License or Registration #: \_\_\_\_\_

Days Per Week of Service: \_\_\_\_\_ Hours: \_\_\_\_\_

Transportation Provided:  Yes  No

Vehicle Insurance:  Yes  No

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/Include phone numbers)

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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: \_\_\_\_\_