SCHOOL READINESS CHILD CARE PROVIDER
INTENT TO CONTRACT
2009-2010

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 Child Care Choice Services (CCCS).

By completing, returning and signing this form, you are notifying the ELCLC and CCCS 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: ____

Will Pruitt, Chair ♦ B. E. Thompson, Vice-Chair
414 W. Main St. Suite 301, Leesburg, Florida 34748
(352) 435-0566 Lesha Buchbinder, Executive Director

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?

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____

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) completed:

☐ ITERS	☐ ECERS	☐ FCCERS	☐ Yes ☐ No	Date:________	Score:_______	☐ Passed ☐ Failed
☐ ITERS	☐ ECERS	☐ FCCERS	☐ Yes ☐ No	Date:________	Score:_______	☐ Passed ☐ Failed
☐ ITERS	☐ ECERS	☐ FCCERS	☐ Yes ☐ No	Date:________	Score:_______	☐ Passed ☐ Failed

Coalition Staff Signature: ________________________________ Date Approved: ____________