

CONNECTICUT STATE DEPARTMENT OF PUBLIC HEALTH CHILD DAY CARE LICENSING UNIT
Notification of Proposed Changes in Child Day Care Centers and Group Day Care Homes

ALERT: Any Change that requires a new application must be submitted to the department 60 days prior to the anticipated date of opening.

1. Name of Program Facility Address: Street & City/Town License # Phone #
2. Mailing Address: (If different or changed)

Completed by: _____ Title: _____ Date: _____

Please Check Applicable Sections Regarding CHANGES

PHYSICAL PLANT CHANGES: (Description) _____

WATER SUPPLY CHANGES: (Enclose attachment 10b)

PROGRAM CHANGES REQUESTED: (Notify DPH at least 30 days prior to requested change)

- a. Current Licensed Capacity: _____ Proposed Licensed Capacity: _____
- b. Current Under 3 Capacity _____ Proposed Under 3 Capacity _____
- c. Current Ages Served: _____ Proposed Ages Served: _____
- d. Current Months, Days & Hours of Operation: _____
(e.g., Sept.-Dec., MWF – 9:00 a.m.-12:00 p.m.)
Proposed Months, Days & Hours of Operation _____

e. **CURRENT LICENSE CATEGORIES:** **PROPOSED LICENSE CATEGORIES:**

- | | | | |
|-----------------|--------------------------|-------------------|--------------------------|
| 1. Children 3-5 | <input type="checkbox"/> | 1. Children 3 – 5 | <input type="checkbox"/> |
| 2. Under 3 | <input type="checkbox"/> | 2. Under 3 | <input type="checkbox"/> |
| 3. School Age | <input type="checkbox"/> | 3. School Age | <input type="checkbox"/> |
| 4. Night Care | <input type="checkbox"/> | 4. Night Care | <input type="checkbox"/> |

CHANGES IN PLANS, POLICIES & PROCEDURES (Notify DPH within 5 days of change)
Policies, Plans & Procedures must be kept on site at your program for department review) – Do Not Submit a Copy Indicate which policy, plan or procedure changed: _____

Changes in Service Contracts or Current Agreements with Consultants, Practitioners & Agencies
(Notify DPH within 10 days of change) Service Contracts/Agreements must be kept on site at your program for department review)

Health Dental Social Service Education Dietician

NEW DIRECTOR: Name: _____

Date of Hire: _____ Work Schedule (Days/Hours): _____

NEW HEAD TEACHER: Name: _____

Date of Hire: _____ Work Schedule (Days/Hours): _____

Other: _____

RETURN THIS FORM TO: Department of Public Health, 410 Capitol Avenue – MS#12 DAC

P.O. Box 340308, Hartford, CT 06134-0308

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