Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

MICHAEL L. PARSON, GOVERNOR • JENNIFER TIDBALL, ACTING DIRECTOR

REGINALD E. MCELHANNON, INTERIM DIRECTOR
CHILDREN'S DIVISION
P.O. BOX 88 • JEFFERSON CITY, MO 65103-0088
WWW.DSS.MO.GOV • 573-522-8024 • 573-526-3971 FAX

Dear Child Care Provider Registration Applicant:

The Department of Social Services (DSS) registers license-exempt child care programs to become child care providers for families eligible to receive Child Care Subsidy through the DSS. Summer camp programs are not required to be licensed child care providers, but are required to obtain a Certificate of Registration and sign a Child Care Provider Agreement with DSS to be paid for services provided to families eligible for Child Care Subsidy.

If you have been determined to be a license-exempt summer camp program by the Department of Health and Senior Services, Section for Child Care Regulation, you must meet the requirements detailed in the attached "Child Care Provider Application Instructions and Checklist for License-Exempt Summer Camp (SUM) Programs" before your registration agreement can be considered for approval.

Included in this packet are documents to assist you in the registration process, resources for technical assistance, and information regarding the Child Care Subsidy program. Read each document in this packet carefully and maintain the information in this packet for future reference.

If you have any questions or require further assistance, please contact us at CD.AskCCPRU@dss.mo.gov

Department of Social Services
Children's Division, Early Childhood Section
Child Care Provider Relations Unit
PO Box 88
Jefferson City, MO 65103-0088

AUXILIARY AIDS AND SERVICES ARE AVAILABLE UPON REQUEST TO INDIVIDUALS WITH DISABILITIES
TDD / TTY: 800-735-2966
RELAY MISSOURI: 711
Missouri Department of Social Services is an Equal Opportunity Employer/Program.

Child Care Provider Application Instructions and Checklist for License-Exempt Summer Camp (SUM) Programs

Complete each step below. Missing information may delay your application.

Submit the following information to the Child Care Provider Relations Unit (CCPRU) at CD.AskCCPRU@dss.mo.gov

☐ 1. Submit, to **CD.AskCCPRU@dss.mo.gov**, the first page of the **Registered Child Care Provider Agreement** (CD-289).

Helpful Tips:

- Carefully read the agreement, then complete and **return the first page only**. Your signature on the agreement means you have read and agree to all the requirements listed in the agreement.
- The agreement must be completed in full. The agreement will not be processed unless all required fields and requirements are completed. Incomplete agreements will be returned to the provider for completion.
- Keep a copy of the completed application for your records.

☐ 2. Submit, to **CD.AskCCPRU@dss.mo.gov**, proof of Taxpayer Identification.

Helpful Tips:

- Acceptable forms of proof include the following:
  1. A copy of a Social Security Card with your correct name and SSN.
  2. If using an EIN (Employer Identification Number) submit one of the following on IRS Letterhead:
     - Submit the notice that was issued by the IRS when you applied for your EIN.
     - Obtain a Letter 147C by contacting the IRS. This verifies your EIN number.

☐ 3. Submit, to **CD.AskCCPRU@dss.mo.gov**, completed **Child Care Provider Staff Listing** form (CD-258).

☐ 4. Submit, to **CD.AskCCPRU@dss.mo.gov**, completed **Comprehensive Background Screening Information** form (CD-273). List the required information for yourself and all staff/volunteers of the facility.

☐ 5. Submit, to **CD.AskCCPRU@dss.mo.gov**, completed **Application for Vendor Direct Deposit** (CD-122) along with a voided check of official letter from your financial institution that includes your name, bank routing number, and account number.

Register for the following:

☐ 6. Register yourself and all staff/volunteers with the Family Care Safety Registry (FCSR). Complete the FCSR application for yourself and all staff/volunteers online at https://webapp02.dhss.mo.gov/bsees/, Maintain FCSR screening results in employee files.

Helpful Tips:

- Submitting your FCSR request online can expedite the registration process.
- There is a one-time registration fee and processing fee, per person, payable by valid credit or debit card. Visit https://webapp02.dhss.mo.gov/bsees/ to view fee amounts.
- If you are already registered with the FCSR, you do not have to pay the fee and register again.
- If at any time during your registration period additional staff/volunteers start providing child care services, the individual needs to be registered immediately with the FCSR.

☐ 7. Register yourself and all staff/volunteers online and submit to fingerprinting through MACHS & IDEMIA at www.machs.mo.gov.

Helpful Tips:

- Individuals without access to the Internet may contact IDEMIA directly at 1-844-543-9712 to speak to a Fingerprint Services Representative.
- The registration number for Early Childhood is **2950**.
- The cost for fingerprinting is $41.75, to be paid by the child care provider/staff member.
- Verify your social security number at the time of fingerprinting.
- Bring your photo ID to your appointment.
- Staff have 90 days from date of hire to complete fingerprinting process.

Fingerprinting must be completed every five (5) years.

☐ 8. Register with OPEN Initiative online at https://www.openinitiative.org/ to complete the following:

1) **Obtain a Missouri Professional Development (MOPD) ID**;
   - The Missouri Professional Development (MOPD) ID is a unique number that you will use throughout your career in the child care field.
   - Refer to the OPEN Initiative website at https://www.openinitiative.org/ for more information about getting an MOPD ID or how to look up your MOPD ID if you think you already have one.
2) **Create a Toolbox account and enroll in the MOPD Registry** at https://www.openinitiative.org/
3) AFTER the registration is approved and you received the DVN and Certification or Registration, the owner or director must **Request Program Level Access and add your MOPD ID number under the facility DVN**.

Helpful Tips:

The Toolbox account is where your training information is stored. Once you create a Toolbox account, you are then required to enroll in the MOPD Registry to track your attendance and completion of trainings obtained through the Workshop Calendar. Completed training cannot be verified until Program Level Access has been granted and you have been added as staff to the facility DVN.

Complete Required Training:

☐ 9. Complete the required CCDF Health and Safety Training (applies to applicant and all staff/volunteers that are responsible for the supervision of children) online at https://apps.dss.mo.gov/CDTraining/.

1) Staff who have already completed Health and Safety Training must complete two (2) hours of training through the Missouri Workshop Calendar online at https://www.moworkshopcalendar.org/.

Have the following on file to be reviewed during the on-site monitoring visit:

☐ 10. Have on file for applicant and staff a Tuberculosis (TB) Risk Assessment Form (MO 580-3015).

- Must be completed, signed, and dated by a medical professional no more than twelve (12) months prior to hire.

Result should indicate the applicant is **not** TB contagious. If at any time a positive result has occurred, staff must obtain a written statement from their physician indicating they do not have contagious or active TB.

Review the Following:

☐ 11. Review the **Child Care Provider Resource List** to learn about important contact information and resources for child care providers.

☐ 12. Emergency Preparedness and Response Plan **–** Child Care Providers are required to have an emergency preparedness and response plan completed and posted along with emergency phone numbers readily available.

Helpful Tips:

- An Emergency Plan Template can be found online at http://health.mo.gov/safety/childcare/forms.php.

☐ 13. Record Keeping – Child care providers are required to keep files on children in their care with basic information. The **Child Care Enrollment Information** form (CD-257) can be used to record information on children in your care.

☐ 14. Attendance – Child care providers are required to keep attendance records on all children in their care. Attendance must include the date care was provided as well as times in and out of care. The **Child Attendance Record By Family Unit** form (CS-109) can be used to record attendance for the children in your care.

IMPORTANT INFORMATION

- This application process is to be considered for registration approval.
- Any costs associated with applying to become a registered child care provider are to be paid by the applicant.

CONTACT INFORMATION

Email the completed application and required documents to:
Email: CD.AskCCPRU@dss.mo.gov

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION – EARLY CHILDHOOD SECTION
CHILD CARE PROVIDER RELATIONS UNIT

CHILD CARE PROVIDER STAFF LISTING

All staff/volunteers must have on file a Tuberculosis (TB) Risk Assessment form completed, signed and dated by a medical professional no more than twelve (12) months prior to hire.

All staff/volunteers responsible for the direct supervision of children must complete any training on specific Health and Safety topics and any training required by the Division.

INSTRUCTIONS: Print the name of the child care provider/facility, DVN, and list the full name for all staff/volunteers. For each staff/volunteer listed indicate (1) if they have a Tuberculosis Risk Assessment on file by circling YES or NO, and (2) if they have completed required training by circling YES, NO, or N/A for 'Not Applicable,' if the staff member/volunteer is required to complete training because they are not responsible for direct supervision of children. Make copies and attach additional sheets if necessary.
Return the completed information to Children's Division, Child Care Provider Relations Unit.

CHILD CARE PROVIDER/FACILITY NAME:_____
DEPARTMENTAL VENDOR NUMBER (DVN):_____

FULL NAME OF ALL STAFF/VOLUNTEERS (Print)	TB Risk Assessment on File (circle YES or NO)		Required Training Completed (circle YES, NO, or N/A)		
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A
	YES	NO	YES	NO	N/A

Mail or fax the completed form to:
Children's Division – Child Care Provider Relations Unit
PO Box 88
Jefferson City, MO 65103-0088
Fax: (573)526-9586

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
COMPREHENSIVE BACKGROUND SCREENING INFORMATION

Six or Fewer (SOF) Providers: Must list the data for yourself (provider) and all household members age 17 years and older.
License-Exempt Providers, including but not limited to, School (SCH), Religious in Compliance (RIC) receiving or applying to receive CCDF Funds, and Business (BUS): Must list data for ALL staff/volunteers responsible for the supervision of children.

INSTRUCTIONS: Please print the name of the child care provider/facility, DVN, and list the full legal name, social security number, and date of birth of persons responsible for the supervision of children as outlined above. Make copies and attach additional sheets if necessary. The information provided below will be used to obtain results of comprehensive background screenings from the Missouri State Highway Patrol and the Family Care Safety Registry (FCSR).

Complete in full and return this document with your Registered Child Care Agreement to:
Mail: Child Care Provider Relations Unit, P.O. Box 88, Jefferson City, MO 65103
Fax: (573) 526-9586 Email: CD.ASKCCPRU@dss.mo.gov

CHILD CARE PROVIDER/FACILITY NAME: _____ **PHONE #:**_____
DEPARTMENTAL VENDOR NUMBER (DVN): _____

FULL LEGAL NAME (Print)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HAS THIS PERSON LIVED IN ANY OTHER STATE(S) IN THE LAST FIVE (5) YEARS? IF YES, PLEASE LIST OTHER STATE(S).	DATE FINGERPRINTS WERE TAKEN
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	

For questions, please contact the Child Care Provider Relations Unit (CCPRU) at 573-526-3011.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
PO BOX 88, JEFFERSON CITY, MO 65103

APPLICATION FOR VENDOR DIRECT DEPOSIT

***Required Fields**

SECTION A *Required Fields Must Be Completed To Avoid Return of the Application and/or Delay in Processing the Application

*1. TYPE OF ACTION (Check Only One) ☐ New Applicant or Re-Enrollment ☐ Change Direct Deposit Information ☐ Cancel Direct Deposit	*2. CONTRACT TYPE OR SERVICE PROVIDED (Check All That Apply) ☐ Child Care ☐ Foster Care/Adoption/Legal Guardianship ☐ Children's Treatment ☐ Residential Treatment ☐ Other (Please Describe):
*3. INDIVIDUAL NAME(S) OR BUSINESS NAME (All names on the contract must be listed here if contract is not under a business name.)	*List Individual Name(s) of Business Owner(s) A. B. C.
*4. ADDRESS (number, street name, city, state, and zip code)	*5. VENDOR NUMBER OR DCN *6. TAX ID/SSN / *7. TELEPHONE NUMBER (include area code) - -

SECTION B *Required Fields Must Be Completed To Avoid Return of the Application and/or Delay in Processing the Application

Note: A voided check or an official letter from your financial institution stating your name, the bank routing number and your account number must be attached to process the Direct Deposit Application. Starter checks and counter checks will not be accepted in place of a check or letter from your financial institution.

*1. NAME OF FINANCIAL INSTITUTION	*2. TYPE OF ACCOUNT (Check Only One) ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT
*3. FINANCIAL INSTITUTION ADDRESS (number, street, city, state, and zip code)	*4. FINANCIAL INSTITUTION TELEPHONE NUMBER (include area code) *5. 9 DIGIT ROUTING NUMBER *6. ACCOUNT NUMBER

SECTION C *Required Fields Must Be Completed To Avoid Return of the Application and/or Delay in Processing the Application

I wish to participate in Direct Deposit and in doing so:

- I (We) hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals), or adjustments for any credit entries made in error to my (our) account designated above.
- I (We) understand that it is my (our) responsibility to notify the Children's Division when a change in banking information is made. This notification must be made at least two weeks prior to the scheduled direct deposit. Without this notification, I (we) understand that payments may be delayed.
- I (We) understand that by endorsing or depositing checks that payment is made from Federal and State funds and any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- I (We) hereby authorize the State of Missouri to initiate payment adjustments made to this account that were intended for another vendor or another account.
- I (We) understand the State of Missouri may terminate my (our) enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason (for example, garnishment orders).
- I (We) understand that the Children's Division may terminate my (our) enrollment if I (we) no longer meet eligibility requirements.
- I (We) understand that this document shall not constitute an amendment or assignment of any nature whatsoever, or any contract, purchase order or obligation that I (we) may have with any agency of the State of Missouri.

All individuals listed on the contract and/or listed as business owners must sign and date the Application for Direct Deposit to authorize initiating, changing, or canceling this Direct Deposit Application.

*SIGNATURE INDIVIDUAL A	*DATE
*SIGNATURE INDIVIDUAL B	*DATE
*SIGNATURE INDIVIDUAL C	*DATE

ALL REQUIRED FIELDS MUST BE COMPLETED TO AVOID RETURN OF THE APPLICATION AND/OR DELAY IN PROCESSING THE APPLICATION
A VOIDED CHECK OR OFFICIAL LETTER FROM YOUR BANK MUST BE ATTACHED TO THIS FORM FOR PROCESSING

RETURN COMPLETED FORM AND ATTACHMENT TO:
CHILDREN'S DIVISION
PO BOX 88
JEFFERSON CITY, MO 65103

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR DIRECT DEPOSIT

SECTION A - All fields in Section A are required fields.

1. Type of Action (Check Only One) – Check the box for the action you would like to accomplish by completing the Application for Direct Deposit.

- New Applicant or Re-Enrollment – Check this box if this is a new request for direct deposit or if you previously had a direct deposit, but it has since closed and you would like to re-open the request.
- Change Direct Deposit Information – Check this box to notify us of any change in the direct deposit request, including, but not limited to, change in routing number or account number, change in contract name, etc.
- Cancel Direct Deposit – Check this box to notify us to cancel the direct deposit request. When the request to cancel the direct deposit is processed, you will no longer receive payments via electronic funds, but will begin to receive paper checks if you are entitled to payment.

2. Contract Type or Service Provided (Check All That Apply)

- Child Care – Check this box if you or your business provides child care (license exempt/registered or licensed/contracted) and may receive payments from the State of Missouri.
- Foster Care/Adoption/Legal Guardianship/Respite – Check this box if you hold a foster care, adoption, legal guardianship, or respite contract/agreement with the State of Missouri.
- Children's Treatment – Check this box if you or your business provide Children's Treatment Services to clients of the State of Missouri.
- Residential Treatment – Check this box if you or your business provide Residential Treatment Services to clients of the State of Missouri.
- Other (Describe) – Check this box and describe what service you provide to clients of the State of Missouri, if none of the above applies to you or your business.

3. Individual Name(s) or Business Name – Write the names of each individual listed on the contract or the name of the business listed on the contract.

- If the contract or agreement has more than one name listed, all names must be listed here.
- If a business name is on the contract or is providing service, list each individual name of the business owner(s) in A, B, and/or C.

4. Address – Write the mailing address, including the number, street name, city, state, and zip code.
5. Vendor Number or DCN – Input your 9 digit Vendor Number (DVN) or 8 digit Departmental Client Number (DCN)
6. Tax ID/SSN – Input your FEIN or Social Security Number
7. Telephone Number – Input a telephone number (including the area code) where you can be reached, should there be any questions about the direct deposit application.

SECTION B - All fields in Section B are required fields.

NOTE: A VOIDED CHECK OR AN OFFICIAL LETTER FROM YOUR FINANCIAL INSTITUTION STATING YOUR NAME, THE BANK ROUTING NUMBER AND YOUR ACCOUNT NUMBER MUST BE ATTACHED TO PROCESS THE DIRECT DEPOSIT APPLICATION. STARTER CHECKS AND COUNTER CHECKS WILL NOT BE ACCEPTED IN PLACE OF A CHECK OR LETTER FROM YOUR FINANCIAL INSTITUTION.

1. Name – Input the name of your financial institution.
2. Type of Account (Check Only One)

- Checking Account – Check this box if payment is to be direct deposited into a checking account.
- Savings Account – Check this box if payment it to be direct deposited into a savings account.

3. Financial Institution Address – Input the address of your financial institution, including number, street name, city, state, and zip code.
4. Financial Institution Telephone Number – Input the telephone number (including the area code) of your financial institution.
5. 9 Digit Routing Number – Input the 9 digit routing number for your financial institution.

- If you are submitting a voided check, the 9 digit routing number can be found at the bottom of your check. The 9 digit routing number is the first set of 9 numbers found at the bottom of the check, towards the left side.

6. Account Number – Input your account number.

- If you are submitting a voided check, the account number can be found at the bottom of your check after the 9 digit routing number or after the check number.

SECTION C - All individuals listed on the contract and/or listed as business owners must sign and date the Application for Direct Deposit to authorize initiating, changing, or canceling this Direct Deposit Application.

Signature Individual A – Individual A must sign and date on this line.
Signature Individual B – Individual B must sign and date on this line.
Signature Individual C – Individual C must sign and date on this line.

In order to allow the Children's Division and the State of Missouri, Division of Finance and Administrative Services to deposit payments into an account, you must complete all of the required fields on the Direct Deposit Application and attach a voided check or an official letter from your financial institution stating your name, the bank routing number and your account number. Starter checks and counter checks will not be accepted in place of a check or letter from your financial institution. With the exception of your signature(s), type or print the required information.

WHAT YOU CAN EXPECT

- **The Direct Deposit Application will be processed when a complete form is received, including all required fields and an attached voided check or letter from your financial institution.**
- **Failure to complete all required fields on the form and attach a voided check or letter from your financial institution will cause the application to be returned to you for correction and will delay processing of the application.**
- **You should begin receiving payments by direct deposit approximately 10-14 days after the Direct Deposit Application has been processed.**
- **If you are entitled to any payments during the time it takes to process the Direct Deposit Application, the payments will be issued as paper checks.**

CHANGING FINANCIAL INSTITUTIONS OR ACCOUNTS

Payments will continue to be deposited in the designated account at your financial institution until you notify the Children's Division you wish to change the financial institution and/or account where the payments are deposited.
To make any changes to the financial institution and/or account where payments are deposited, you must complete a new Direct Deposit Application. All parties listed on the contract and/or listed as business owners, must review and sign, to authorize changes (including cancellations), to the Direct Deposit Application. Failure to notify the Children's Division of a change in account information will result in a delay in receiving your payments.

ALL REQUIRED FIELDS MUST BE COMPLETED TO AVOID RETURN OF THE APPLICATION AND/OR DELAY IN PROCESSING THE APPLICATION
A VOIDED CHECK OR OFFICIAL LETTER FROM YOUR BANK MUST BE ATTACHED TO THIS FORM FOR PROCESSING

RETURN COMPLETED FORM AND ATTACHMENT TO:
CHILDREN'S DIVISION
PO BOX 88
JEFFERSON CITY, MO 65103

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

Patient's Name: _____ **Date of Birth:**_____ **Date:** _____
Address: _____ **Phone Number:** _____

A. Please answer the following questions (Sections A & B to be completed by Patient):	
Have you ever had a positive Mantoux tuberculin skin test (TST)?	☐Yes ☐ No
Have you ever been vaccinated with BCG?	☐Yes ☐ No
Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?	☐Yes ☐ No
Have you ever been diagnosed with or treated for TB Disease?	☐Yes ☐ No
B. <u>TB Risk Assessment</u>	
Have you ever had close contact with anyone who was sick with tuberculosis?	☐Yes ☐ No
Have you ever traveled to one or more of the countries listed below? **If yes, please CHECK the countries.**	☐Yes ☐ No
Were you born in one of the countries listed below? **If yes, please list the country:**_____ What year did you arrive in the United States? _____	☐Yes ☐ No

Afghanistan	Cape Verde	Gabon	Kuwait	Myanmar	St. Vincent &	Tokelau
Algeria	Central African Rep.	Gambia	Kyrgyzstan	Namibia	The Grenadines	Tonga
Angola	Chad	Georgia	Lao PDR	Nauru	Sao Tome & Principe	Trinidad & Tobago
Anguilla	Chile	Ghana	Latvia	Nepal	Saudi Arabia	Tunisia
Argentina	China	Greenland	Lesotho	Nicaragua	Senegal	Turkey
Armenia	Colombia	Guatemala	Liberia	Niger	Serbia	Turkmenistan
Azerbaijan	Comoros	Guinea	Libyan Arab Jamihirya	Nigeria	Seychelles Sierra	Turks & Caicos
Bahrain	Congo	Guinea-Bissau	Lithuania	Niue	Leone	Islands
Bangladesh	Congo DR	Guam	Macedonia-TFYR	Northern Mariana	Singapore	Tuvalu
Belarus	Cote d'Ivoire	Guyana	Madagascar	Islands	Solomon Islands	Uganda
Belize	Croatia	Haiti	Malawi	Pakistan	Somalia	Ukraine
Benin	Djibouti	Honduras	Malaysia	Palau	South Africa	Uruguay
Bhutan	Dominica	Hungary	Maldives	Panama	Sri Lanka	Uzbekistan
Bolivia	Dominican Republic	India	Mali	Papua New Guinea	Sudan	Vanuatu
Bosnia & Herzegovina	Ecuador	Indonesia	Marshall Islands	Paraguay	Sudan - South	Venezuela
Botswana	Egypt	Iran	Mauritania	Peru	Suriname	Viet Nam
Brazil	El Salvador	Iraq	Mauritius	Philippines	Syrian Arab Republic	Wallis & Futuna
Brunei Darussalam	Equatorial Guinea	Japan	Mexico	Poland	Swaziland	Islands
Bulgaria	Eritrea	Kazakhstan	Micronesia	Portugal	Tajikistan	Yemen
Burkina Faso	Estonia	Kenya	Moldova-Rep.	Qatar	Tanzania-UR	Zambia
Burundi	Ethiopia	Kiribati	Mongolia	Romania	Thailand	Zimbabwe
Cambodia	Fiji	Korea-DPR	Morocco	Russian Federation	Timor-Leste	
Cameroon	French Polynesia	Korea-Republic	Mozambique	Rwanda	Togo	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to http://www.who.int/topics/tuberculosis/en/.

Have you ever had an abnormal chest x-ray suggestive of TB?	☐Yes ☐ No ☐ No Response
Are you HIV positive?	☐Yes ☐ No ☐ No Response
Are you an organ transplant recipient or donor?	☐Yes ☐ No ☐ No Response
Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?	☐Yes ☐ No ☐ No Response
Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?	☐Yes ☐ No ☐ No Response
Do you have any medical conditions such as diabetes, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal)?	☐Yes ☐ No ☐ No Response
Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats?	☐Yes ☐ No ☐ No Response
Are you coughing up blood or phlegm?	☐Yes ☐ No ☐ No Response

I hereby certify that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

_____ _____
Patient Signature (Required) Date:

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

C. Medical Evaluation (Section C to be completed by Health Care Provider – if needed)

Health Care Provider: If the answer to any of the TB Risk Assessment questions in Section B is YES or NO RESPONSE, proceed with additional medical evaluation as appropriate. Additional evaluation may include one or more of the following: TST, IGRA, sign and symptom review, chest x-ray, or sputum collection. If the patient is immunosuppressed and no previous TB test is documented, an IGRA is recommended.

1. **Tuberculin Skin Test (TST) -** Please provide a 2-step TST for those at high risk that have no documentation of a previous TST: Administer 1st step TST today and read in 48-72 hrs, if the 1st step TST is positive, document the results in millimeters (mm)of induration and follow the evaluation steps for a positive TST. If the 1st step TST is negative document the results in mm of induration. Results of mm of induration, transverse diameter; if no induration write "0" mm. The TST interpretation* should be based on mm of induration as well as risk factors. Place a 2-step TST in one to three weeks after the first TST was read and recorded. The 2-step should be read in 48-72 hrs and then follow the documentation procedures as outlined above .

Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____
Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____

***TST Interpretation Guidelines (Please check all that apply).**

>5 mm is Positive:
- ☐ Recent close contacts of an individual with infectious TB
- ☐ Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- ☐ Organ transplant recipients
- ☐ Immunosuppressed persons: taking ≥ 15 mg/d of prednisone for ≥ 1 month; taking a TNF-α antagonist
- ☐ Persons with HIV/AIDS

>15 mm is Positive:
- ☐ Persons with no known risk factors for TB disease

> 10 mm is: Positive:
- ☐ Persons born in a high prevalence country or who resided in one for a significant amount of time
- ☐ History of illicit drug use
- ☐ Mycobacteriology laboratory personnel
- ☐ History of resident, worker or volunteer in high-risk congregate settings
- ☐ Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
- ☐ Children < 4 years of age
- ☐ Children and adolescents exposed to adults in high-risk categories

2. **Interferon Gamma Release Assay (Please check the IGRA that is used)**

QFT-G ☐ QFT-GIT ☐ **Date Obtained**: _____
Result: ☐ Responsive (TB Infection Likely) ☐ Nonresponsive (TB Infection Unlikely) ☐ Indeterminate
T- Spot ☐ **Date Obtained**: _____
Result: ☐ Negative ☐ Positive ☐ Borderline/Equivocal
Other: _____ **Date Obtained**: _____ **Result:**_____

3. **Chest X-ray: (Required if TST or IGRA is positive)**

Date of Chest X-ray: _____ **Result:** ☐ Normal ☐ Abnormal
Abnormal Chest X-ray Interpretation: _____

4. **Sputum Collection: If the patient has a positive TST or IGRA and a productive cough > 3weeks, with or without hemoptysis,** please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters of specimen per tube.

1. Date Obtained	**Smear Result:**	**Culture Result:**	**2. Date Obtained:**	**Smear Result:**	**Culture Result:**
_____	_____	_____	_____	_____	_____
3. Date Obtained:	**Smear Result:**	**Culture Result:**			
_____	_____	_____			

An isolate on any positive mycobacterium cultures should be sent to the Missouri State Public Health Laboratory.

I have reviewed the above information with the patient and deemed: ☐ **No Further Evaluation Needed** ☐ **Further Evaluation is Needed**

_____ _____
Health Care Provider Signature (Required) Date:

All positive TST, IGRA, chest x-ray, smear and culture results suggestive of tuberculosis disease or latent tuberculosis infection should be reported to the Missouri Department of Health and Senior Services (fax number: 573-526-0235) or your local public health agency using this form. If you have any questions, please contact the Bureau of Communicable Disease Control and Prevention at 573-751-6113.

CHILD CARE PROVIDER RESOURCE LIST

Child Care Provider Relations Unit
PO Box 88
Jefferson City, MO 65103-0088
Phone: (573) 526-3011
Fax: (573) 526-9586
Email: CD.AskCCPRU@dss.mo.gov

Missouri Registered Child Care Monitoring Unit
PO Box 105215
Jefferson City, MO 65110
Phone: 1-888-690-1027
Email: MOChildCareMonitoring@pcgus.com

Jefferson City Child Care Payment Unit
PO Box 88
Jefferson City, MO 65103
Phone: (573) 522-1385
Fax: (573) 526-2926
Email: CD.AskCCOIS@dss.mo.gov

St. Louis Child Care Payment Unit
*Serves St. Louis County and St. Louis City
9900 Page Ave.
St. Louis, MO 63132
Phone: (314) 264-7632
Fax: (314) 264-7699
Email: CD.AskSTLCCPRU@dss.mo.gov

Child Care Online Invoice System (CCOIS)
https://apps.dss.mo.gov/CCONLINE//wbFMB9LogonCCInv.asp

Child Care Business Information Solution (CCBIS)
Phone: 833-866-1709 Option 9
Email: SupportMO@Controltec.com

Direct Deposit Application (CD-122)
http://dss.mo.gov/cd/info/forms/
To receive payment by direct deposit, complete an Application for Vendor Direct Deposit (CD-122) and return to the Child Care Provider Relations Unit.

Child Care Rate Structure by County
https://apps.dss.mo.gov/childcarerates/

OPEN Initiative
Phone: 573-884-3373
Email: openinitiative@missouri.edu
Website: https://www.openinitiative.org/

Missouri Workshop Calendar (Administered by Child Care Aware® of Missouri)
http://www.moworkshopcalendar.org/

Child Care Subsidy Orientation Training
https://apps.dss.mo.gov/childcareorientation/

Department of Health and Senior Services
Section for Child Care Regulation (for licensing information)
http://health.mo.gov/safety/childcare/index.php

Educare
Find contact information for your local Educare office at https://dss.mo.gov/cd/child-care/child-care-providers/educare.htm

Child Abuse and Neglect Hotline
1-800-392-3738
Website: http://dss.mo.gov/cd/can.htm

Child and Adult Care Food Program
Department of Health and Senior Services
Phone: 1-800-733-6251
Website: www.dhss.mo.gov/cacfp

Child Care Aware® of Missouri
1000 Executive Parkway Dr. Suite 103
St. Louis, MO 63141
Phone: 800-200-9017
Fax: 314-754-0330
Website: www.mo.childcareaware.org

Safe Sleep Practices for Child Care Providers
http://www.healthychildcare.org/PDF/SIDSchildcaresafesleep.pdf

Ready in Three (Disaster Preparedness Information)
Department of Health and Senior Services
http://health.mo.gov/emergencies/readyin3/childcare.php

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION - EARLY CHILDHOOD SECTION
CHILD CARE ENROLLMENT INFORMATION

CHILD'S INFORMATION

CHILD'S FULL NAME	DATE OF BIRTH
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
LIST OF KNOWN ALLERGIES (e.g., foods, medications, insects or other materials):	
LIST OF DAILY MEDICATIONS, INCLUDING INFORMATION ON DOSAGE, TIME OF ADMINSTERING, AND METHOD FOR ADMINISTERING:	
FOR INFANTS ONLY – LIST FEEDING TIMES, AND AMOUNT OF BREAST MILK OR FORMULA PER FEEDING:	

PARENT/GUARDIAN INFORMATION

MOTHER'S/LEGAL GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK BOX IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	WORK TELEPHONE NUMBER
FATHER'S/LEGAL GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK BOX IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	WORK TELEPHONE NUMBER

PERSONS AUTHORIZED TO PICK-UP AND DROP-OFF

LIST OF PERSONS AUTHORIZED BY THE LEGAL GUARDIAN TO PICK-UP AND DROP-OFF THE CHILD:

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT AND CHILDREN'S DIVISION
CHILD ATTENDANCE RECORD BY FAMILY UNIT

CHILD CARE PROVIDER NAME	PROVIDER DEPARTMENTAL VENDOR NUMBER (DVN)	PROVIDER TELEPHONE NUMBER
PARENT OR DESIGNEE NAME		PARENT OR DESIGNEE DCN
PARENT OR DESIGNEE ADDRESS		
PARENT OR DESIGNEE TELEPHONE NUMBER		

MONTH/ YEAR	CHILD # 1 NAME (FIRST/LAST)				PARENT MUST INITIAL EACH DAY OF CARE	CHILD # 2 NAME (FIRST/LAST)				PARENT MUST INITIAL EACH DAY OF CARE
	CHILD # 1 DCN					CHILD # 2 DCN				
DAY OF MONTH	TIME CARE BEGAN AM OR PM	TIME CARE ENDED – CHILD LEAVING TO RETURN TO CARE SAME DAY ONLY	TIME CARE BEGAN – CHILD RETURNING TO CARE SAME DAY ONLY	TIME CARE ENDED AM OR PM		TIME CARE BEGAN AM OR PM	TIME CARE ENDED – CHILD LEAVING TORETURN TO CARE SAME DAY ONLY	TIME CARE BEGAN – CHILD RETURNING TO CARE SAME DAY ONLY	TIME CARE ENDED AM OR PM	
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I certify that the hours and days of care listed above were provided to the above named children.

PARENT SIGNATURE	CHILD CARE PROVIDER SIGNATURE

PROVIDER NOTE: All child care providers are required to maintain daily attendance records for subsidy eligible children. Daily attendance records must include the time care began and the time care ended, initialed by the parent/designee, on each day of care. Attendance must be recorded on the same day care is provided. Complete and legible, original attendance records must be submitted with original invoices, for payment.