

QUALITY COUNTS QUALITY RATING SYSTEM



Application for:
Illinois License-Exempt Family Child Care Providers

Overview

The Quality Counts-Quality Rating System (QRS) assists Illinois License-Exempt family child care (LEFCC) providers in providing quality care for children and their families. This voluntary system offers three Training Tiers which providers can achieve. Once a License-Exempt family child care provider has completed training for a Training Tier, they receive a QRS Training Tier award certificate. Providers serving children eligible for the Child Care Assistance Program (CCAP) receive a quality add-on to the CCAP standard daily reimbursement rate. Add-on rates range from 10% – 20% depending on the Training Tier(s) a provider has completed. Providers do not have to have CCAP children in care in order to apply to QRS.

Eligibility Requirements

- Providers must attend the LEFCC Quality Rating System Orientation session before applying for QRS. The orientation is offered by the local CCR&R or online at www.ilgateways.com under online training. If you have not attended a QRS Orientation, contact your local CCR&R or go online to find dates and times of upcoming sessions. To find a local CCR&R visit the Gateways website at www.ilgateways.com or call **1-866-697-8278**.
- Completed, at a minimum, the training requirements for Training Tier 1. To receive the CCAP quality add-ons shown on the Training Tier chart, Tiers must be completed in order. Providers can apply for each Tier once they have completed required trainings. (*See Training Tier Chart on next page 2*)

Directions for Completing the QRS Application

The application must be fully completed. Required documentation must be enclosed with the signed and dated application. Any missing information will delay the processing of your application. Send **copies** of all documentation. Information submitted to INCCRRA will not be returned.

1. Complete the Provider Information section.
2. Complete the Program Information section, including:
 - Indicate the Training Tier you are applying for.
 - Complete the LEFCC QRS Orientation attendance information. Confirm training is showing on your Gateways PDR.
 - Complete information about child care provided. If CCAP children are in care, submit copies of the previous month's CCAP billing certificates for all CCAP children in care.
3. Complete the Training Tier checklist for the Tier you are applying for.
4. Sign and date the application.
5. Applications are processed by the Illinois Network of Child Care Resource & Referral Agencies (INCCRRA). IDHS is notified of eligible providers. The quality add-on rate for CCAP providers goes into effect the month following notification of eligibility. This initiative is funded by the Illinois Department of Human Services (IDHS).

Training Checklist - Training will be verified through Gateways Registry

| TIER | TRAINING TIER 1 | TRAINING TIER 2 | TRAINING TIER 3 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------|
| Number of Modules | 4 Modules (Approximately 12 contact hours) | Tier 1 PLUS 4 Modules (Approximately 12 contact hours) | Tiers 1 & 2 PLUS 8 Modules (Approximately 24 contact hours) |
| <input type="checkbox"/> LEFCC ORIENTATION MUST BE COMPLETED BEFORE APPLYING | | | |
| Required Training Modules | <input type="checkbox"/> Overview of Child Development | <input type="checkbox"/> Observation and Guidance | <input type="checkbox"/> Child Development (Birth to 8 Months) |
| | <input type="checkbox"/> Health Issues for Group Care | <input type="checkbox"/> Learning Happens in Relationships | <input type="checkbox"/> Child Development (8 to 18 Months) |
| | <input type="checkbox"/> Nutrition Issues for Group Care | <input type="checkbox"/> Family & Community Relationships | <input type="checkbox"/> Child Development (18 to 36 Months) |
| | <input type="checkbox"/> Safety Issues for Group Care | <input type="checkbox"/> Personal & Professional Development | <input type="checkbox"/> Preschool Social and Emotional Development |
| | | | <input type="checkbox"/> Preschool Physical Development |
| | | | <input type="checkbox"/> Preschool Language Development |
| | | | <input type="checkbox"/> Preschool Cognitive Development |
| | | | <input type="checkbox"/> School-Age Development |
| CCAP Rate Add-on | 10% | 15% | 20% |
| <p>Notes:</p> <ul style="list-style-type: none"> • To receive the listed CCAP rate add-on, a provider must complete Training Tiers in order. • A provider must complete training in any one tier within a 2-year timeframe. • Completion of all three Training Tiers will result in award of the Gateways to Opportunity ECE Credential Level 1. | | | |

QRS Application Checklist

Before submitting your application please make sure the following are completed and enclosed:

- Application is fully completed
- Signature and date on application
- Copy of previous month's CCAP billing certificates if CCAP children are in care

Mail completed application to: INCCRRA/QRS • 1226 Towanda Plaza • Bloomington, IL 61701

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Provider Information

Provider Name: _____ Registry Member ID: _____

If serving child care assistance program (CCAP) children you must provide your 15 digit provider number(s) you receive payment under. *Failure to provide this will result in missed add-ons, if available.*

Provider Number(s) _____
This number can be found directly after your name on the CCAP documentation.

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Phone: () _____ SS# or FEIN: _____

Date of Birth: ___ / ___ / _____ Email: _____ Sex: F M

What is the highest education level you have completed?

- High School/ GED Some College Associate Degree Bachelor's Degree Master's Degree
 CDA (*Child Development Associate*) Professional Educator Licensure Other _____

Have you completed coursework in Child Development or Early Childhood Education? Yes No

Race (*optional*): African American Asian Caucasian/White Hispanic Native American Other

Program Information

Training Tier Applying for: Training Tier 1 Training Tier 2 Training Tier 3

Hours providing child care: _____ AM to _____ PM

Days providing care: Mon Tues Wed Thurs Fri Sat Sun

Please check one: Full Year (*Serving children at least 47 weeks*) School Year (*minimum of 9 months*)

Total number of children in care, including your own, under the age of 13 _____

Total number of children in each age group:

Infants (6 wks-14 months) _____ Toddlers (15-23 months) _____ Twos (24-35 months) _____

Preschool (3-5 yrs) _____ School age (K-12 yrs) _____

Are you currently caring for IDHS CCAP children? Yes No

If "Yes", how many CCAP children are in care? _____ (*Attach copies of previous month's CCAP billing certificates for all CCAP children in care.*)

Primary language spoken to children: English Spanish Other

How did you learn about QRS? CCR&R SEIU Union Provider Association Conference Website Other

Required Signature

I verify that the above information is accurate. I understand that if I provide inaccurate or false information, the program may be ineligible and/or suspended from participation in the Quality Counts-Quality Rating System Program. By signing below I understand that INCCRRA will use my signature to verify any information and documents I have submitted. I understand that IDHS may use my name and application information for research/evaluation purposes. IDHS has the right to audit program records and documents.

Provider Signature: _____ Date: _____

Release of Information (optional)

By signing below, I grant INCCRRA permission to release my name and contact information to the media, CCR&R, public policy advocates, IDHS, legislators and others for the purpose of recognition as a QRS participant.

Provider Signature: _____ Date: _____

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