VARIANCE REQUEST FOR CAPACITY AND AGE DISTRIBUTION

MN Rule 9502.0315 – 9502.0445
Family and Group Child Care Providers

Provider Name: License #:

Address:

License Classification: Phone number:

1. Why do you want a variance from Rule 9502? How will you be out of compliance?

2. This variance is being requested for (child's name) . The child's DOB is . The additional child that makes the request necessary is (child's name) and DOB is . ***These could be the same or different children***

3. Could you change your license classification instead of getting a variance?

4. Is there someone that can help you instead of OR during the variance time period? Who?

5. Is this a new or existing family?

6. For what period of time is the variance requested?
   From To Total # of days/months
   Total # of Hrs. in each day

   Which days of the week and what hours of those days is the variance needed?

7. Please write a detailed plan for how you will ensure the health, safety and protection of all the children in your care if this variance is granted (including additional equipment, caregivers, training etc.):

8. Have you received variance approvals in the past 12 months? If yes, what were the total number of days?

9. Are you on a Food Program?

Please complete the current enrollment list (page 3) including the child(ren) that will put you over your capacity. The variance child is the one that will age up allowing you to be back within your capacity.

You must attain parent signatures on page 4 and include with this request. A request will be denied if you fail to do this.

Provider Signature ________________________ Date ______________

	Child's Name and Parents Names	DOB	Age	GROUP I/T/P/S	Days/Hours in care
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					

Chisago County – Notification of Variance – Parent Statement

I am requesting a capacity variance from Chisago County Child Care Licensing on my allowable capacity so that I may care for an additional child in the age group (ie. I, T, P, S)
I will be over my licensed capacity for the following time period if the variance is approved.
From (Month/Day/Yr) to (Month/Day/Yr) x (#days/wk) = Total # of days

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Please sign below to indicate that you have been informed of this capacity request. All families enrolled in care must sign (including the child that puts the provider over their capacity).

	Printed Name	**Signature**	**Date**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			