

**FAMILY CHILD CARE HOME INSPECTION REPORT**

| INSPECTION DATE/TIME/DURATION:<br><b>3/9/2026 9:47 AM</b>                                                                     |                                                            | <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th colspan="2">INSPECTION TYPE</th></tr> <tr><td><input type="checkbox"/></td><td>Initial Application</td></tr> <tr><td><input type="checkbox"/></td><td>Conversion</td></tr> <tr><td><input type="checkbox"/></td><td>Mandatory Review</td></tr> <tr><td><input type="checkbox"/></td><td>Full</td></tr> <tr><td><input type="checkbox"/></td><td>Complaint Investigation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Monitoring</td></tr> <tr><td><input type="checkbox"/></td><td>Other</td></tr> </table> <div style="margin-top: 5px;"><input type="checkbox"/> Follow Up</div> |           | INSPECTION TYPE                |  | <input type="checkbox"/> | Initial Application | <input type="checkbox"/> | Conversion | <input type="checkbox"/> | Mandatory Review | <input type="checkbox"/> | Full | <input type="checkbox"/> | Complaint Investigation | <input checked="" type="checkbox"/> | Monitoring | <input type="checkbox"/> | Other | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>AGES</th> <th>Registered for</th> <th># Enrolled</th> <th># Present</th> <th>Resident Children</th> </tr> <tr> <td>0-23 Months</td> <td>4</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td>2's</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>4</td> <td>3</td> <td>0</td> </tr> <tr> <td>3's</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>2</td> <td>1</td> <td>0</td> </tr> <tr> <td>4's</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td>5's (pre-school)</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>5-12 (school-age)</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td><b>TOTAL</b></td> <td></td> <td>8</td> <td>6</td> <td>0</td> </tr> <tr> <td>Overnight</td> <td></td> <td>0</td> <td>0</td> <td>XXXXXX</td> </tr> <tr> <td>Head Start</td> <td>XXXXXXXX</td> <td>0</td> <td>XXXXXX</td> <td>XXXXXX</td> </tr> </table> |  |  | AGES | Registered for | # Enrolled | # Present | Resident Children | 0-23 Months | 4 | 1 | 1 | 0 | 2's | <input checked="" type="radio"/> Y <input type="radio"/> N | 4 | 3 | 0 | 3's | <input checked="" type="radio"/> Y <input type="radio"/> N | 2 | 1 | 0 | 4's | <input checked="" type="radio"/> Y <input type="radio"/> N | 1 | 1 | 0 | 5's (pre-school) | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | 5-12 (school-age) | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | <b>TOTAL</b> |  | 8 | 6 | 0 | Overnight |  | 0 | 0 | XXXXXX | Head Start | XXXXXXXX | 0 | XXXXXX | XXXXXX |
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| INSPECTION TYPE                                                                                                               |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                                                                      | Initial Application                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                                                                      | Conversion                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                                                                      | Mandatory Review                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                                                                      | Full                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                                                                      | Complaint Investigation                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input checked="" type="checkbox"/>                                                                                           | Monitoring                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                                                                      | Other                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| AGES                                                                                                                          | Registered for                                             | # Enrolled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | # Present | Resident Children              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 0-23 Months                                                                                                                   | 4                                                          | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 2's                                                                                                                           | <input checked="" type="radio"/> Y <input type="radio"/> N | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 3's                                                                                                                           | <input checked="" type="radio"/> Y <input type="radio"/> N | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 4's                                                                                                                           | <input checked="" type="radio"/> Y <input type="radio"/> N | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 5's (pre-school)                                                                                                              | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 5-12 (school-age)                                                                                                             | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <b>TOTAL</b>                                                                                                                  |                                                            | 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6         | 0                              |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| Overnight                                                                                                                     |                                                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0         | XXXXXX                         |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| Head Start                                                                                                                    | XXXXXXXX                                                   | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | XXXXXX    | XXXXXX                         |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| REGION:<br><b>12</b>                                                                                                          |                                                            | Fatality:<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |           | Serious Injury:<br><b>0</b>    |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| EXCELS LEVEL:<br><b>1</b>                                                                                                     |                                                            | COMPLAINT #:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| ACCREDITED: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N                                                  |                                                            | ACCREDITED BY:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           | EXP DATE:                      |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| HOMEOWNER'S INSURANCE COVERAGE: <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           | EXP DATE:<br><b>10/18/2026</b> |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| BUSINESS NAME:                                                                                                                |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| PROVIDER NAME:<br><b>Satwinder Singh</b>                                                                                      |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| CO-PROVIDER:                                                                                                                  |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| ADDRESS:<br><b>6617 River Birch Road</b> <b>Frederick</b> <b>MD</b> <b>21703</b>                                              |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| PERSONS INTERVIEWED:<br><b>Satwinder Singh</b>                                                                                |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| TITLE(S):<br><b>Provider</b>                                                                                                  |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| TELEPHONE:<br><b>(240) 477-9229</b>                                                                                           |                                                            | E-MAIL:<br><b>monasingh1590@gmail.com</b> <span style="float:right;"><input checked="" type="radio"/> Verified <input type="radio"/> N/A</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                |  |                          |                     |                          |            |                          |                  |                          |      |                          |                         |                                     |            |                          |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |

**PART 1 - MANDATORY REVIEW ITEMS**

INSTRUCTIONS: (1) Review each regulation that applies to the inspection being conducted.  
 (2) The compliance status of an item listed under Part 2 may be recorded when deemed necessary.  
 (3) Initial/Resumption/Conversion/Full Inspection - Complete both Part 1 and Part 2.

**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable**

|                    |                                     |                 |                                                    |
|--------------------|-------------------------------------|-----------------|----------------------------------------------------|
| <u>C</u> .02.01D   | Certificate Conspicuously Displayed | <u>X</u> .06.02 | Training Requirements                              |
| <u>C</u> .03.04A   | Emergency Forms                     | <u>X</u> .07.01 | Prohibition of Abuse, Neglect, Injurious Treatment |
| <u>X</u> .03.05C-E | Notification of Changes             | <u>X</u> .07.02 | Abuse and Neglect Reporting                        |
| <u>C</u> .04.03    | Child Capacity                      | <u>C</u> .07.04 | Child Discipline                                   |
| <u>C</u> .05.03    | Cleanliness and Sanitation          | <u>C</u> .07.07 | Child Security                                     |
| <u>C</u> .05.04    | Rooms Used for Care                 | <u>C</u> .08.01 | General Child Supervision                          |
| <u>C</u> .05.05    | Outdoor Activity Area               | <u>C</u> .10.02 | Potentially Hazardous Items                        |
| <u>C</u> .05.06    | Rest Furnishings                    | <u>X</u> .10.06 | Rest Time Safety                                   |

**PART 2 – GENERAL COMPLIANCE REVIEW**

INSTRUCTIONS: The compliance status of an item listed under Part 1 is excepted (exc.) from recording under Part 2.

**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable**

**CHAPTER 02 REGISTRATION APPLICATION AND MAINTENANCE**

|               |                         |
|---------------|-------------------------|
| <u>X</u> .03B | Continuing Registration |
| <u>X</u> .04B | Conditional Status      |

**CHAPTER 03 MANAGEMENT & ADMINISTRATION**

|              |               |
|--------------|---------------|
| <u>X</u> .01 | Advertisement |
|--------------|---------------|

**CHAPTER 03 MANAGEMENT & ADMINISTRATION, CON'T**

|              |                          |
|--------------|--------------------------|
| <u>X</u> .02 | Admission to Care        |
| <u>X</u> .03 | Program Records          |
| <u>X</u> .04 | Child Records [exc. A]   |
| <u>X</u> .05 | Notifications [exc. C-E] |
| <u>X</u> .06 | Variances                |

|                                                  |
|--------------------------------------------------|
| <b>PART 2 – GENERAL COMPLIANCE REVIEW, CON'T</b> |
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**INSTRUCTIONS:** The compliance status of an item listed under Part 1 is excepted (exc.) from recording under Part 2.

|                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>C</u> = In Compliance, <u>D</u> = Discussed, <u>N</u> = Not in Compliance, <u>X</u> = Not Inspected, <u>NA</u> = Not Applicable</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------|

**CHAPTER 04 OPERATIONAL REQUIREMENTS**X.01 Hours of CareX.02 Age Group Enrollment**CHAPTER 05 HOME ENVIRONMENT & EQUIPMENT**X.01 Suitability of the HomeX.02 Lead-Safe Environment**CHAPTER 06 PROVIDER REQUIREMENTS**X.03 Provider SubstituteX.04 Additional AdultX.05 Volunteers**CHAPTER 07 CHILD PROTECTION**X.03 Applicability to ResidentsX.05 Parental AccessX.06 Authorized Release**CHAPTER 08 CHILD SUPERVISION**X.02 Off-Site SupervisionX.03 Water Activity SupervisionX.04 Overnight Care Supervision**CHAPTER 09 PROGRAM REQUIREMENTS**X.01 ActivitiesX.02 Materials/EquipmentX.03 Rest Periods**CHAPTER 10 SAFETY**X.01 Emergency SafetyX.03 Outdoor SafetyX.04 Water SafetyX.05 Transportation Safety**CHAPTER 11 HEALTH**X.01 Child Comfort/WelfareX.02 Exclusion for Acute IllnessX.03 Infectious/Communicable DiseasesX.04 Medication Administration/StorageX.05 SmokingX.06 Consumption of Alcohol/Drugs

**PART 2 – GENERAL COMPLIANCE REVIEW, CON'T**

**INSTRUCTIONS:** The compliance status of an item listed under Part 1 is excepted (exc.) from recording under Part 2.

**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable**

**CHAPTER 12 NUTRITION**

X.01 Nutrition/Food Served  
X.02 Food Storage/Cleanliness

**CHAPTER 13 INSPECTIONS, COMPLAINTS & ENFORCEMENTS**

X.01 Inspections  
X.06 Emergency Suspension



\_\_\_\_\_  
Signature of Provider



\_\_\_\_\_  
Signature of Agency Representative  
Erin Ringley

**3/09/2026**

\_\_\_\_\_  
Date