SUPPORTING FAMILY, FRIEND AND NEIGHBOR CAREGIVERS: FINDINGS FROM A SURVEY OF STATE POLICIES

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Introduction

Child care provided by family, friends and neighbors (kith and kin) who are exempt from state licensing requirements has emerged as a major public child care policy issue since the passage of the 1996 federal welfare reform legislation. National data indicate that these types of arrangements represent a significant proportion of the care for children under five whose parents are working. According to the most recent census report, relatives represent the largest category. Grandparents alone account for 30**%** of all child care arrangements for children in this age group, with other relatives, including siblings, accounting for another 15**%** (Smith, 2002).[1]

Recent studies show that family, friend and neighbor care also represents a significant proportion of Child Care and Development Fund (CCDF) subsidized child care. In some states, it accounts for more than half of Temporary Assistance to Needy Families (TANF) child care subsidies (Child Care and Development Fund, Table 6, FFY 2001). For example, approximately 66% of child care dollars in Illinois are expended on kith and kin care; in New Mexico and Connecticut, 70% of subsidized children are in these child care arrangements (Anderson, Ramsburg, & Rothbaum, 2003; Cindy Davies, personal communication, September 3, 2004; Wilson-Coker, 2002).

The growing evidence of the number of children who spend their days, and sometimes their nights, in publicly subsidized kith and kin child care arrangements has affected attitudes about it. Until the change in federal welfare policy, little attention was paid to this type of child care. Most of the initiatives to improve child care quality focused on regulated settings in centers or family child care. Many child care research studies did not even consider family, friend and

[1] Friends and neighbors who are not licensed as family child care providers represent another 10%. Other studies point to similar findings. Data from the National Survey of America's Families, a nationally representative sample of 44,000 households, indicate that relatives represent close to 30% of the primary non-parental child care arrangements for employed mothers with preschool children. Family child care providers, individuals who provide child care in their homes for a small number of children, represent 21% (Capizzano & Adams, 2004).

neighbor care.[2] In the past several years, federal and state policy makers have come to recognize that these caregivers play a significant role in the supply of child care.

One consequence of these changed perceptions is increased attention to questions about how to protect and support children in license-exempt child care arrangements. Health and safety is an important concern, because these settings are exempt from the regulations that apply to licensed child care centers and family child care homes. Another concern is children's readiness for school, particularly their cognitive and language development, because family, friend and neighbor caregivers have, until recently, been exempt from pre-service or in-service training standards that apply to regulated providers.

Purpose

Because family, friend and neighbor care is used by such a large number of families who are eligible for publicly subsidized child care, we sought to learn more about state policies for these child care settings. The research had a twofold purpose: first, we aimed to enhance the understanding of the context in which these caregivers provide child care; and second, we intended to stimulate discussions about approaches for improving the quality of care that these caregivers offer. The study focused on several issues: 1) how states define home-based care that is exempt from regulations for family child care; 2) the kinds of requirements that states impose on license-exempt home-based caregivers who provide care for subsidized children; and 3) the types of special initiatives, if any, that states fund to improve the quality of care that these caregivers offer to children.

Methodology

To answer these questions, we conducted a telephone survey of state child care administrators in 2004. Initial interviews focused on regulatory policy, requirements for caregivers who provide

[2] The Family Child Care and Relative Care study, which was conducted in 1994, was the major exception (Kontos, Howes, Shinn, & Galinsky, 1995.)

child care for publicly subsidized children, and initiatives specifically intended for family, friend and neighbor care. To learn more about the initiatives, we interviewed the program operators and we reviewed selected training curricula.[3]

A total of 48 states responded to the survey. Second-round interviews were conducted with 20 program operators to obtain detailed information about the initiatives that had been identified. Preliminary findings were shared with the respondents to verify that the data were accurate.

This paper presents the results of the research in four sections. The first section describes the conditions under which caregivers who provide child care in their own homes are exempt from licensing requirements. The next section focuses on state requirements for license-exempt caregivers who provide child care for children in the subsidy system. The third section presents findings about state efforts that aim to improve the quality of care that these caregivers offer. The final section discusses the implications of these policies for family, friend and neighbor care as well as the children who rely on it each day.

Section I: State Licensing Requirements for Home-based Caregivers

The 1996 Personal Responsibility and Work Opportunity Act represented a major shift in federal welfare policy. It required mothers who received financial support from TANF funding, even those with children under three, to work (Public Law 104-193 sec. 407). Through the CCDF, the legislation provided funding to the states to subsidize child care for eligible families, those who received welfare payments as well as those who had found jobs and were still within income guidelines.

CCDF regulations "promote parental choice to empower working parents to make their own decisions on child care that best suits that family's need" by requiring states to offer parents a

[3] For an analysis of these curricula, please contact the Institute for a Child Care Continuum at Bank Street College of Education.

choice between an eligible child care provider who has a grant or contract to provide child care services or a child care certificate to purchase care (CCDF, §98.1(a)(2) and §98.30(a)). Options include care in regulated child care centers and family child care (where the provider cares for a small number of children in her own home) as well as in care that is exempt from state regulations. These license-exempt settings fall into two categories: center-based programs such as those in faith-based institutions and care provided by individuals in their own homes or the child's home (CCDF, §98.3 (a)).

In all 50 states, relatives of the child are exempt from licensing requirements (National Child Care Information Center, 2001). CCDF defines relatives as parents, siblings who live in separate residences, aunts or uncles, grandparents, and great-grandparents (CCDF, §98.3 (a)). Some states extend the definition to include other extended family members depending on the relationship to the child. In Utah, for example, parents can use their child care subsidies to pay step-grandparents and ex-grandparents for care.

State exemptions from licensing requirements for individuals who provide care in their own homes vary widely. The three major factors that distinguish legally-exempt home-based care from family child care that is subject to licensing requirements are the number of children in care at one time, the number of families who rely on the caregiver, and the amount of time children spend with her. There is a wide range of thresholds for the number of children in care. Among the states that responded to our survey, the most common threshold for licensing is three children who are not related to the provider: eleven states permit home-based caregivers who provide child care for this minimum number to operate without a license as a family child care provider (Table 1).

Some states set more stringent thresholds for licensing. Seven permit home-based caregivers to care for only two children as license-exempt providers. Other states have less restrictive standards. Five states permit caregivers to care for four; five allow caregivers to operate without a license if they care for five children; and four states set the limit at six.

A small number of states do not use the number of children in care as the basis for exemption from licensing. Instead, they set limits on the number of families in care or the number of hours a child can remain in care (Table 1).[4] Home-based caregivers in California, Minnesota, and Florida can provide legally exempt care for an unlimited number of children as long as they are from the same family, whether or not the family is related to her. In Alabama and Oklahoma, home-based caregivers who provide care for a single child who is not related to them for more than four and 15 hours a week respectively must be licensed as family child care providers.

Twelve states use a combination of these factors to differentiate between home-based caregivers who are subject to licensing and those who are exempt from it (Table 1). More than half of these states—eight—set limits on the number of children as well as the number of families in care. Montana, for example, requires caregivers who care for more than two children from different families to operate as regulated family child care providers; if there are more than two children from the same family irrespective of their relationship to her, the caregiver can provide child care without a license.

Other states, like Arkansas, Connecticut, Kansas and New York, set limits on the number of hours in care as well as the number of children. Kansas state regulations require licensing for relative and non-relative caregivers who care for more than one child for more than 20 hours a week, while New York's licensing regulations apply to anyone who cares for more than two unrelated children for three hours or more. Arkansas requires anyone who provides care for more than five children in her home for more than five hours if paid (less than ten hours if unpaid) to be licensed; providers in Connecticut can care for as many as six children who are not related to them as long as they are only in care for fewer than three hours.

Section II: State Requirements for Family, Friend and Neighbor Caregivers in the Subsidy System

[4] These limits are generally imposed on non-relatives.

One of the primary concerns for state policy makers who administer child care subsidy programs is ensuring children's health and safety, irrespective of the licensing status of the setting. Federal CCDF regulations delineate some minimum standards that states must apply to all providers who care for subsidized children. The premises must be safe; infectious diseases must be prevented and controlled; and providers must receive some health and safety training (PRWORA, 1998; CCDF § 98.41).[5] States can comply with these requirements in a variety of ways. They may also impose higher standards, which many do.

The strategies that states use to protect subsidized children's health and safety in license-exempt child care typically fall into four categories. One is background checks to identify individuals who may represent a danger to the child because of prior criminal histories or founded allegations of child abuse or neglect. Another is self-certifications or attestations by the caregiver about the features of the home, child care practices, or the arrangement. The third is mandatory participation in orientations or training. And the fourth category is home visitation required at least once a year, but sometimes more frequently.

Background Checks

The majority of states require license-exempt caregivers who provide child care for subsidized children to undergo some kind of background check. Of the 48 states in our survey, 39 require family, friend, and neighbor caregivers who are reimbursed with public funds for child care to comply with this process. By contrast, one in five states (nine) in our survey do not require any kind of background check.[6]

The most common background check for license-exempt providers who care for subsidized children is a state criminal record check for some kind of conviction. Of the 39 states that require background checks, 32 subject caregivers to this requirement (Table 2). Most of them, 25,

[5] Immunizations are not required for children in relative child care.
[6] They are: Alabama, Idaho, Mississippi, Nevada, New York, Ohio, Oklahoma, South Carolina and Utah.

compel all license-exempt providers—relatives and non-relatives—to undergo a state criminal history check. Three states—California, Massachusetts, and South Dakota—only require these checks for non-relatives, and all of the states that only exempt relatives require them to undergo this process.[7]

The range of crimes that disqualify caregivers from receiving publicly funded reimbursement for providing child care is wide. Some states, like Arizona, will not pay caregivers who have histories of crimes like murder, rape, or child molestation that could pose a direct and severe threat to children. Others, like Oregon, exclude caregivers who have been convicted of many crimes, irrespective of the nature or seriousness, from eligibility for reimbursement although some crimes are subject to statute of limitations.[8]

Another commonly used background check for license-exempt caregivers in the subsidy system is a check for histories of child abuse and neglect. Four in five of the six states that require any kind of background check (32 of the 39) use this approach (Table 2). Most of these states (25) require a criminal records check as well.

Some states also require checks of Federal Bureau of Investigation (FBI) finger print records to identify criminal histories. This kind of background check provides information about contacts with the criminal justice system in any state across the country. Only 16 states subject license-exempt caregivers to this procedure. Almost all of them—14—also require criminal history and child abuse checks (Table 2).[9]

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[7] Michigan, which exempts non-relatives if they have been in the United States for less than four weeks or if the parents are present, is counted as a "relatives only" state because the definition for non-relatives is so stringent.

[8] For a discussion of these issues, please see Porter, T. & Mabon, S. (2004). *Policy Issues in License-Exempt Child Care: Lead Paint, Wages, and Criminal Record Checks.* New York: Bank Street College of Education. Http://www.bankstreet.edu/iccc.

[9] Hawaii only requires a child abuse and an FBI check. Oregon only requires criminal background and FBI checks. California and Maine do not require fingerprint checks but they provide the option for caregivers to undergo this procedure to provide information to parents.

Several states require only one kind of background check. Louisiana, Massachusetts, and Wisconsin use criminal background checks exclusively, while Colorado, Illinois, Kansas, Maryland, and New Jersey only require child abuse and neglect background checks. Six states require caregivers to have an FBI check only under certain conditions.[10] They are Arkansas, Montana, North Carolina, Oregon, Pennsylvania and West Virginia.

Slightly more than half (22 of the 39) states that use some kind of background check requirements for license-exempt providers who care for subsidized children extend these requirements to other members of the household. Twenty-two require criminal background checks. The majority of them (16) also require child abuse and neglect record checks for household members, and five require them to undergo a fingerprint record check. In most cases, these requirements only apply to household members who are adults over the age of 18, but six states impose one or more checks on younger adolescents. For example, Minnesota requires criminal record and child abuse checks for household members who are 13 or older, while New Jersey subjects youth 14 and older to child abuse checks.

Self-Certifications

Nearly three quarters of the states in the survey, 35, require license-exempt caregivers who seek to provide child care to subsidized children to complete self-certifications (Table 3). Typically, these consist of attestations that the caregiver must sign and submit to the state before payment for child care is provided. Most of these states impose this requirement in addition to background checks, but three—Idaho, New York, and Utah—use attestations instead of a criminal background check. By contrast, Oklahoma and South Carolina require neither self-certifications nor background checks.

Most of the states that require self-certifications (28 of the 35) use them to address health and safety issues. For example, Washington requires caregivers to attest that they use basic health

[10] For example, Arkansas, Montana and North Carolina require FBI checks only if the caregiver has lived in the state less than six, five or five years respectively.

practices and provide appropriate discipline, while Rhode Island asks caregivers to certify that there are no personal health issues, that emergency numbers for the child are available, and that there is a fire escape plan. North Carolina asks caregivers to complete a health and safety checklist. Kansas and Montana require a working phone. Caregivers in Montana must also certify that they have had a tuberculosis test. As part of its self-certification, Louisiana requires a fire marshal inspection of the home; caregivers in Georgia must agree to a monitoring visit.

In four states, the conditions of the self-certification are minimal and do not pertain to health and safety. Caregivers in Alabama must certify their relationship to the child, while those in Nevada and New Jersey must document that they have signed an agreement with the parent about the child care arrangement and payments. In both cases, the parent must sign the self-certification as well. Michigan requires caregivers to certify that they are related to the child and that they understand the requirements for reimbursement.

New York's self-certification, on the other hand, is extensive. It requires caregivers to attest that a long list of health and safety features are present and that the caregiver uses basic health and safety practices. In addition, it requires the caregiver to provide information about criminal convictions as well as founded child abuse allegations, because the state does not require background checks.[11]

Required Orientation and Training

Mandated orientation sessions represent an opportunity to explain state requirements for participation in the child care subsidy system and to provide caregivers with information about a variety of issues. Close to a third of the states in our survey, 14, require license-exempt caregivers to participate in these sessions before they can provide care for subsidized children

[11] Caregivers must include any criminal conviction, but there is case-by-case appeals process if the caregiver seeks to void the disqualification.

(Table 3).[12] Three of these states—Arkansas, Georgia and Kentucky—do not use self-certifications.

Most of the orientations focus on reimbursement procedures—how to complete and submit required paperwork, but three states include information about health and safety in the orientation. Massachusetts is one example. In a one-and-a-half-hour orientation, Child Care Resource and Referral (CCR&R) agency staff explain the subsidy system and give providers tip sheets about topics that range from putting children to sleep on their backs to reading to children. They also offer information about CCR&R training workshops for family child care providers. Kentucky's orientation is another example. It requires caregivers to participate in a three-hour CCR&R orientation (or on-line for a fee), which includes health, safety and discipline as well as guidelines for identifying and reporting abuse and neglect.

Approximately one third of the states in our survey (15) require family, friend and neighbor caregivers to participate in training workshops about providing child care as a condition of receiving reimbursement for providing child care (Table 3). Most require the training in addition to an orientation that focuses on the subsidy systems.[13] Basic health and safety practices such as hand-washing and diapering procedures are most common topics: eight states cover this kind of content in their required training.

Other topics include Pediatric Cardio-Pulmonary Respiration (CPR) and First-Aid. Six states require caregivers to complete CPR, and four, First-Aid. Some states also offer other topics such as identifying child abuse, nutrition, and Sudden Infant Death Syndrome. Two states include information on child development.

The number of hours of training that caregivers must complete to participate in the subsidy system ranges from three to 10, with three as the most common. The specific content of the

[12] New York and Michigan offer counties the option to mandate these sessions.
[13] They include: Arizona, Arkansas, California, Georgia, Idaho, Nevada, New Mexico, and Rhode Island.

required training varies. South Dakota's mandated three-hour training, for example, includes CPR as well as health and safety, while Georgia's required eight hours focuses exclusively on health and safety. By contrast, Arkansas' 10 hours of training includes a session on child development in addition to these topics.

Home Inspections

Six states require home inspections for license-exempt caregivers who provide care to subsidized children (Table 3). Georgia, Idaho, and New Jersey require caregivers to agree to one home inspection; Louisiana makes one unannounced home visit annually. Two states require more than one home visit. Arizona requires two annual visits, and Arkansas makes three visits during the year. Nevada requires home visits for non-relative caregivers, during which it provides health and safety kits.

A number of states do not impose any requirements at all on family, friend and neighbor caregivers in the subsidy system. Oklahoma and South Carolina do not mandate background checks, self-certifications, orientations, trainings, or home inspections. The requirements in Alabama, Mississippi, New York and Utah are minimal: they only require self-certifications.

Conversely, Arizona, New Mexico and Rhode Island have high levels of requirements for license-exempt caregivers to care for subsidized children. Of the three, Arizona has the highest level, mandating that caregivers have all three kinds of background checks, complete a self-certification, attend an orientation, fulfill training requirements and have a home inspection. New Mexico and Rhode Island follow closely: the only requirement they do not impose is a home inspection.

Section III: Specific Initiatives for Family, Friend and Neighbor Care

Of the 48 states that responded to the survey, 20 have developed some kind of special initiative to improve child care quality in license-exempt child care (Table 4). Three states—Connecticut,

Michigan, and Minnesota—fund two separate initiatives, bringing the total number of initiatives in the survey to 23. The vast majority of these initiatives are limited to caregivers who provide child care to subsidized children.

The most common approaches for improving the quality of care provided by family, friends and neighbors are training and professional development activities.[14] Training initiatives consist of workshops, without the option of academic credit, that aim to enhance providers' knowledge and skills. Professional development initiatives, on the other hand, consist of workshops or courses that lead to academic or career advancement in the field.

Initiatives that use these two strategies account for half of the special efforts for license-exempt caregivers. Nine use training. They include: Alabama's Kids and Kin Program; California's License-Exempt Training; the Denver County/City Family, Friend and Neighbor Training; Illinois' License-Exempt Pilot; Kansas' Relative Care Pilot; Michigan's Better Kids Care Pilot and its FUTURES initiative; Minnesota's Kith and Kin Program; and Nevada's Distance Learning Project. Two initiatives, Connecticut's Charts-A-Course modules for kith and kin caregivers and New Mexico's Conversations Pilot, use professional development as a strategy. Caregivers who complete these activities receive credit in the states' career development systems.

With two exceptions, the remaining initiatives identified in the survey are equally divided between those that use distribution of materials and equipment as a strategy and those that use technical assistance. Each accounts for five initiatives. The former include: Arizona's Kith and Kin Project; Connecticut's Commissioner's Initiative; Hawaii's Learning to Grow; Minnesota's Readmobile, and New York's Project for Kith and Kin Caregivers. Those that rely on technical assistance are: Alaska's Rural Outreach Initiative; Louisiana's Family Child Care Visitation Program; Missouri's Project Rural Early Childhood (REACH) program; New Jersey's Approved

[14] The description of child care quality improvement strategies uses the typology developed in Porter, T., Habeeb, S., Mabon, S., Robertson, A., Kreader, L., & Collins, A. (2002). *Assessing Child Care Development Fund Efforts to Improve Child Care Quality: A Study of Selected State Initiatives.* New York: Bank Street College of Education.

Home Provider program; and South Dakota's Technical Assistance Support. Four of the technical assistance initiatives—Alaska, Louisiana, Missouri and New Jersey—provide this support through home visits. South Dakota, on the other hand, stations caseworkers at field offices to help caregivers with the reimbursement process.

The two other initiatives include Indiana's Child Care Health Consultant Program, its Healthy Child Care America program, and New Hampshire's Provider Appreciation Day. The Child Care Health Consultant Program uses multiple strategies to provide support to family, friends and neighbors, while the Provider Appreciation Day represents a way to recognize the important role that family, friends and neighbors play in the child care system.

A small number of states in the survey indicate that they include kith and kin caregivers in efforts that aim to improve child care in regulated settings, but they do not fund any specific initiatives. Examples range from Idaho's CCR&R training and Pennsylvania's Pathways career development system to newsletters that several states mail to license-exempt caregivers as well as licensed child care providers.[15] One state, Oregon, pointed to its tiered reimbursement system, which includes kith and kin, as an effort to improve child care quality in these settings. Typically, there is no special outreach to family, friend and neighbor caregivers.

Initiative Characteristics

More than half of the initiatives specifically intended for kith and kin caregivers have been developed since 2000, six in 2004 alone. The newest include three pilot programs—Kansas' Relative Care Pilot, Michigan's Better Kids Care Pilot, and New Mexico's Conversations, New Hampshire's Provider Appreciation Day, and two initiatives, California's License-Exempt Training and Minnesota's Readmobile, that have not yet begun to offer services, although they were funded early in 2004. Only Alabama's Kids and Kin Program, Michigan's FUTURES, and

[15] In Massachusetts, the CCR&Rs send quarterly newsletters to caregivers who have participated in the mandatory orientation, while Maine sends its Maine Roads to Quality child development newsletter, which is developed by its career development system, to any caregiver who participates in the subsidy program. Nevada's monthly newsletter, which is prepared by the Children's Council, is sent to anyone who cares for subsidized children.

Missouri's Project REACH have operated for more than four years. (FUTURES began in 1990, Project REACH started in 1994, and Alabama has been serving caregivers since 1999.)

Most of the initiatives only serve caregivers who provide care for subsidized children. They include seven training initiatives, New Mexico's professional development pilot, all of the efforts that distribute materials and equipment, all of those that provide technical assistance, and the two initiatives in the "other" category. Four initiatives are open to any license-exempt provider. They are Alabama's, California's, and Minnesota's training initiatives as well as Connecticut's Charts-A-Course career development modules.

Recruitment and Incentives

Training and Professional Development Activities. All of the training initiatives that serve providers who care for subsidized children use mailings to the subsidy list as a recruitment strategy. Some use other strategies as well. The Metropolitan Chicago YWCA CCR&R, which offers training workshops for license-exempt caregivers in DuPage and Kane County, makes presentations at other community organizations to recruit caregivers, especially those who speak Spanish. CCR&Rs in Alabama distribute fliers about the Kids and Kin Program at Head Start programs, family service organizations, and WalMart stores in addition to making presentations throughout their communities (for example, schools, neighborhood associations meetings, political gatherings), wherever people gather. The program is also publicized through public service announcements and paid advertisements in local newsletters. The two professional development initiatives, Connecticut's Charts-A-Course and New Mexico's Conversations, depend on word of mouth as well as some of the other strategies.

Six training initiatives rely on some kind of incentives to encourage participation in the workshops. The incentives usually consist of cash or materials. Three of the pilot programs use this strategy. Michigan's Better Kids Care Pilot offers cash, $150 for completion of 15 hours of training, while caregivers in Kansas's Relative Care Pilot receive $100 in materials. They can also receive a 10-cent increase in their reimbursement rate if they complete the training. Illinois'

License-Exempt Pilot, on the other hand, offers both cash and materials. It provides $100 for completion of all its training sessions as well as health and safety equipment, books and math manipulatives.

Some of the established training initiatives also use incentives. Alabama's Kids and Kin Program provides $75 worth of materials for its Level 1 training and an additional $100 for Level 2, while caregivers in Michigan's FUTURES can receive a $150 bonus for completion of the 15 hours of training. Those who provide care for infants and toddlers are also eligible for a 25-cent increase in their reimbursement. Minnesota's Kith and Kin Project provides different kinds of incentives. Caregivers in the Somali support groups, for example, received headscarves to encourage their participation.

Materials and Equipment and Technical Assistance. Like the training initiatives, those that distribute materials and equipment use mailings to the subsidy list to recruit caregivers. Some of the technical assistance initiatives also use phone calls. The CCR&Rs in Louisiana, for example, call caregivers as a first step and then follow-up with a mailing.

Other. Indiana's Child Care Health Consultant Project primarily uses targeted advertising. It sets up display boards at meetings or conferences of organizations that attract kith and kin caregivers. It also distributes press releases and relies on word of mouth. New Hampshire used mailings to the subsidy list to invite caregivers to its Provider Appreciation Day brunch, but it believes that word of mouth will attract providers next year as well.

Mailings to caregivers who provide care for subsidized children are the most common type of recruitment approach, irrespective of the strategy of the initiative. Anecdotal data from several efforts, however, seem to indicate that mailings alone may not be effective. For example, one initiative reported that letters to 400 caregivers only attracted 20 participants. According to staff in some programs, other approaches such as presentations and leafleting that are followed by personal phone calls seem to be more successful.

Program Design

Training and Professional Development Activities. The duration of the training workshops ranges from a single two-hour workshop to an 18-hour series, with individual sessions averaging two hours in length. Some initiatives offer the training in a single day, while others extend the period over two days or a full week. Still others provide a weekly workshop series for several months.

Kansas' Relative Care Pilot two-hour workshops are offered on weekday evenings, while the Illinois and Michigan pilot programs schedule their trainings during the course of one week. The Illinois Pilot offers its 10-hour training in two-hour evening workshops, four nights a week and one Saturday morning, although two workshops are sometimes scheduled as back-to-back sessions on Saturday. It also schedules two follow-up workshops after the initial training and offers home visits to distribute materials and equipment through its quality van program. Michigan's Relative Care Project follows the same general approach. Four three-hour sessions are offered during the week, with another six-hour session on CPR and First Aid on Saturday.

Alabama, Michigan, Minnesota and New Mexico extend their workshop series over a longer period. Minnesota's support groups are offered on a weekly basis for 12-16 weeks as are those in Michigan's FUTURES. New Mexico's two-hour Conversations sessions are also scheduled on a weekly basis; the nine sessions are offered during a two- to three-month period. Most sessions are offered in the evening, but some sites offer them on Saturday. By contrast, the schedule for the two-hour Kids and Kin Level 1 and Level 2 workshops varies between one and three workshops per month over an approximately four-month period.

Connecticut and Nevada use different approaches. The five Connecticut's Charts-A-Course three-hour modules are scheduled at different times and locations throughout the academic year. There is no required sequence for completing the workshops nor must caregivers complete all five of them. Unlike the other efforts, Nevada uses distance learning to offer training to

caregivers. It mails self-guided modules on a wide range of topics that are linked to the state's Early Learning Standards. The initiative also offers a warm-line to answer caregivers' questions as well as grants for home improvements such as fence repair. It will also pay for CPR training.

Materials and Equipment. The initiatives that provide materials and equipment use different kinds of distribution strategies. Caregivers in Connecticut can obtain kits by participating in support group training or home visits. In its Hit The Streets program, (part of the New York Kith and Kin Caregivers Project) New York City uses home visits as well.[16] The University of Hawaii, by contrast, mails materials to caregivers on a monthly basis. Caregivers who indicate that they have used the activities receive a children's book as a "reward." (Minnesota's Readmobile plans to make 52 one-hour weekly visits to caregivers' homes to provide books and help caregivers understand how to support emerging literacy.)

Technical Assistance. Program designs differ among the four technical assistance initiatives that make home visits. Missouri's Project REACH offers these visits once a month during the year. The visits generally begin with an informal assessment of the caregiver's strengths and weaknesses, and then focus on improving different aspects of care. The home visitors provide a variety of tip sheets that are geared to a sixth grade reading level.

By contrast, Louisiana and New Jersey only provide a small number of visits after the initial required home inspection. Louisiana makes one visit annually, with a focus on compliance with regulations and reimbursement procedures, while New Jersey offers caregivers the opportunity for two or three visits in which the staff provides some materials and equipment as well as information about other training opportunities. Nevada's home visits are an optional service for relative caregivers who request them.

[16] Initially, it distributed the kits through vans stationed in neighborhoods or required caregivers to pick up their kits at CCR&R offices.

Other. Indiana's Child Care Health Consultant Project provides trainings on health and safety through single workshops and a workshop series. It also distributes tips sheets and a health and safety resource kit that consists of basic supplies such as plastic disposable gloves for medical procedures and electrical outlet covers. In addition, the initiative offers home visits to evaluate the health and safety of the caregivers' homes and to create a home improvement plan. Technical assistance is available by phone. New Hampshire's Provider Appreciation Day, on the other hand, consists of a single activity, a brunch, for caregivers. A wide variety of gifts, including books, wagons for infants, and materials for science activities are distributed to caregivers, and CCR&R staff are available to provide information about trainings and other services.

Program design varies across strategies. Among the training initiatives, traditional workshops offered by a trainer in a stand-up format are the most common. One of the professional development initiatives also uses this approach, while the other uses support groups. These facilitated discussions seem to have appealed to participants: many of them have created informal networks after the series ends.

The designs used by the initiatives that distribute materials and equipment fall into two categories: those in which materials are provided through home visits and those that mail materials without any face-to-face contact between the staff and the caregiver. With the exception of the planned Readmobile program, there is usually only a single visit to the caregiver's home. By contrast, the range of technical assistance initiative visits extends from one to more than ten annually.

Content

Training and Professional Development. Most of the training and professional development initiatives cover similar topics. They include health and safety, child development, and discipline. Of the 10 initiatives that are currently serving caregivers, nine offer workshops on health and safety, some aspect of child development, and discipline. Seven include workshops on

literacy. A smaller number offer workshops on working with parents. Only five of the initiatives cover this material. (One training initiative focuses exclusively on health and safety.)

Much of the content for the workshops is drawn from materials for training for regulated family child care providers. Only a few initiatives—Alabama's, Connecticut's, and Minnesota's—acknowledge the special circumstances of family, friend and neighbor care.

There is some variation in the emphasis of individual workshops. Connecticut's Charts-A-Course modules on child development, for example, focus on cognitive development, while temperament is the focus of Illinois' License-Exempt Pilot's workshop on this topic. By contrast, Michigan's Better Kids Care Pilot's child development workshop covers all domains. In Arizona, Illinois, Minnesota and New Mexico, the training is available in Spanish.

Materials and Equipment and Technical Assistance. Most of the initiatives distribute similar materials to caregivers. Kits often include health and safety equipment such as smoke detectors or cabinet locks. In addition, Connecticut provides tapes of children's songs and coloring books, while Arizona's lending libraries offer videos and materials for play. New York and Hawaii include tip sheets about a variety of topics; Hawaii sends four publications from its Family Resource Kit as well. Arizona, Connecticut and New York provide materials in Spanish.

Three of the technical assistance initiatives that make home visits also provide some materials. New Jersey offers health and safety equipment, materials for play, tip sheets and books. Louisiana offers books as well, while Missouri provides tip sheets on a variety of topics including licensing.

The content of all of the initiatives, irrespective of strategy, focuses on some of the same topics, many of which apply to regulated family child care settings, and to some extent, regulated center care as well. Health and safety and child development are common topics (although child development is most often covered as a single workshop.) There is also some consistent attention

to literacy: seven of the training initiatives include this topic, and books are often included in the materials that are provided to caregivers.

By contrast, less emphasis is paid to topics that have particular relevance for kith and kin caregivers. One is working with parents, an issue that is particularly important in these settings because the caregiver's relationship with the parent and the child is the distinguishing feature in kith and kin care. Another overlooked topic is information about licensing, which may appeal to some kith and kin caregivers.

Auspices

Most of the initiatives that aim to improve quality in family, friend and neighbor care turn to CCR&Rs to offer services. They are the most commonly used service delivery agency for the training initiatives as well as those that offer materials and equipment and technical assistance. Among the other organizations that provide services, institutions of higher education are most common.

Training and Professional Development Activities. Of the nine initiatives that use training as a strategy, eight rely exclusively on CCR&R agencies to deliver services. Illinois' License-Exempt Pilot and Kansas' Relative Care Pilot use them as does Minnesota's Kith and Kin Project, which began to offer services in 2003. CCR&Rs also offer the FUTURES training in Michigan, Colorado's workshops and Nevada's distance learning modules. Alabama's Kids and Kin Program, too, is housed at CCR&Rs, although it uses community-based trainers as well. (The California's License-Exempt Training workshops will be offered by members of the California Child Care Resource and Referral Network.)

Only one training initiative do not use CCR&Rs to offer services. Michigan's Better Kids Care Pilot workshops are provided by Michigan State University, which has offered a 36-hour course for family child care providers for nearly a decade. The two professional development initiatives rely on organizations or trainers that have been approved by the career development system.

Connecticut uses approved training organizations to offer its Charts-A-Course modules for license-exempt providers, and New Mexico relies on trained facilitators for its Conversations pilot support group training.

Materials and Equipment. Three of the five initiatives that distribute materials and equipment also use CCR&Rs. Arizona's Kith and Kin Project, Connecticut's Commissioner's Initiative, and New York's Kith and Kin Project all contract with them to deliver services.[17] By contrast, the University of Hawaii provides the materials in Learning to Grow, and the Hennepin County Library operates the Readmobile program in Minnesota.

Technical Assistance. CCR&Rs deliver services in three of the five initiatives that use technical assistance as an approach for improving quality. Louisiana turns to them (and an infant/toddler initiative), for its home visiting program; CCR&Rs also provide the home visits in Alaska and New Jersey. On the other hand, the University of Missouri operates Project REACH, which aims to serve caregivers and centers that serve subsidized children in rural areas. (Its counterpart, Educare, serves caregivers and centers in urban communities.) South Dakota relies on state caseworkers at Native American reservation child care offices to provide the technical assistance to caregivers.

Other. Indiana's Child Care Health Consultant Project is housed at the Indiana Institute of Disability and Community at Indiana University. It is part of the Early Childhood Center. New Hampshire's Provider Appreciation Day was organized by the state Department of Health and Human Services, although CCR&Rs participated in the brunch.

Staff Qualifications

Training and Professional Development Activities. Trainers in most of the training initiatives are often experienced at working with adults. Many have delivered training to family child care

[17] Arizona also relies a community-based organization as well as the Cooperative Extension service, while Connecticut uses family resource centers in addition to CCR&Rs.

providers. Connecticut uses only approved trainers for Charts-A-Course; Kansas, Michigan and New Mexico require college degrees with specializations in early childhood for their program staff. Most organizations do not provide in-service training or special training for staff on working with license-exempt providers.

Technical Assistance. Staff qualifications for the technical assistance initiatives that offer home visiting vary. Project REACH home visitors—Professional Development Associates—have BA degrees with an early childhood specializations. They have usually directed centers, and have years of experience in these child care settings. In-service training is offered regionally every four to six weeks; two conferences for staff are organized twice a year. In general, these meetings focus on policy or regulatory issues, although the regional meetings cover staff concerns as well.

Qualifications for staff in the Louisiana and New Jersey initiatives are broader. Educational levels can vary from some college to graduate degrees; home visitors have a range of early childhood experiences. Neither initiative offers formal in-service training for home visitors. By contrast, the librarians in Minnesota's Readmobile initiative have master's degrees in library science, with specializations in working with young children. The initiative has also provided in-service training on emerging literacy and literacy as well as the challenges faced by families in poverty.

Scope and Size

Training and Professional Development Activities. Training initiatives and professional development initiatives for license-exempt caregivers vary in scope from one or two counties to statewide. Several of the pilot initiatives are small: New Mexico's is offered in one county; Illinois' in two; and Michigan's in five. Kansas' Relative Care Pilot is somewhat larger, serving 11 counties in one area of the state, while Colorado's training is offered in Denver County, which includes the city of Denver.

By contrast, some of the established programs cover most or all of the state. The Charts-A-Course modules in Connecticut are available statewide as are Michigan's FUTURES trainings.

The number of participants served by the pilot initiatives varies widely. Kansas' Relative Care Pilot trained 17 caregivers in 2004, its first year; Michigan's Better Kids Care Pilot, which was initiated in the same period, trained 17 caregivers in the first site in Saginaw County. Two other pilots, Illinois' License-Exempt Pilot and New Mexico's Conversations, reached larger numbers of caregivers. Illinois offered workshops to 56 caregivers in the last 12 months; 90 caregivers completed New Mexico's series in the first nine months of the year.

Older training initiatives that are larger in scope serve more caregivers. In the past four years, there have been 500 Kids and Kin participants; 54 caregivers completed Level 1 and 72 completed Level 2 in 2003-2004. In addition, Kids and Kin maintains a database of 1,500 caregivers who receive its newsletter. Connecticut estimates that approximately 550 caregivers, 10% of those who have received health and safety kits, have participated in the training, and Michigan's FUTURES trained 945 caregivers in the past 12 months. Nevada's distance learning program served 168 caregivers in the same period.

Materials and Equipment. The number of participants served in initiatives that distribute materials and equipment is considerably larger than those who participate in training initiatives. Connecticut's Commissioner's Initiative, which is available in 18 communities, distributed 400 kits in Hartford alone in 2004. Arizona served 457 caregivers through the lending libraries in the past 12 months; Hawaii served 4,200 caregivers in the same period. Approximately 1000 caregivers obtained kits in New York City in 2004. (Minnesota's Readmobile aims to serve 25 caregivers in the first year.)

Technical Assistance. In 2004, Project REACH served 359 programs of which 52 were license-exempt family, friends and neighbors. New Jersey provided home visits to 617 caregivers in the

past 11 months (without reports from two counties), and Louisiana reported visits with 180 caregivers in Region 1 for the first six months of the year.

Other. Of the 3000 caregivers invited to New Hampshire's Provider Appreciation Day, 30 attended.

Among the initiatives, those that offer materials and equipment serve the largest number of caregivers. Efforts that provide technical assistance follow. The training initiatives serve smaller numbers of participants, but several of them are new pilot efforts that have only operated for short period. If the record of the older efforts that aim to enhance providers' knowledge and skills is any indication, these numbers may increase over time.

Section IV: Discussion

The role that family, friends and neighbors who are exempt from state licensing requirements play in child care supply is now widely accepted. Kith and kin care is the child care of choice for many parents. Some want caregivers whom they know and trust or caregivers who share their language and culture (Anderson et al., 2003; Drake, Unti, Greenspoon, & Fawcett, 2004; Porter, 1991; Todd, 2004). Other parents use kith and kin child care because the hours are flexible and fit their work schedules. Still others use it because it costs less than child care in other settings; in some cases, there may be no fee at all.

The reasons that large numbers of families in the subsidy system rely on family, friends and neighbors for child care are unclear. Some research points to parents' choice, but other factors may influence the use of these arrangements. The supply of regulated child care in centers or family child care homes may be small, for example, or subsidy payment levels and co-payment requirements may constrain their use. Whatever the explanation, the reality is that many families use these arrangements.

Our study aims to examine two primary questions. First, we sought to understand the circumstances under which care in the provider's home is exempt from the standards that apply to regulated home-based care with family child care providers. Second, we wanted to learn how states address issues of child care quality in these settings.

One of the most striking findings from our survey relates to the distinctions states create between home-based care that is subject to licensing and care that is exempt from these regulations. The variation is wide. Some states require anyone who cares for even one unrelated child to become a regulated family child care provider, while other states do not set a limit on the number of children in care if they are all from the same family. Several states use both the number of children and the number of families in care; still others set limits based on the number of children and the hours in care.

The practical consequences of these differences are clear. Caregivers who are exempt from licensing requirements in some states are subject to them in others. Depending on where they live, license-exempt caregivers who care for subsidized children may be required to comply with the same kinds of requirements that states impose on regulated family child care providers.

Our findings show that states use a number of different approaches to ensure that subsidized children are safe in child care arrangements with family, friends and neighbors. Among them are background checks, self-certifications, mandated participation in orientations or trainings, and home inspections. The data indicate that there is little uniformity or consistency in states' use of these strategies. A few states do not impose any of these requirements on caregivers who want to provide child care for subsidized children, while others use all of them. In the middle ground are those states that apply a combination of requirements—background checks, self-certifications and orientations, for example--or background checks, orientations and trainings.

It is difficult to determine if any of these approaches is effective. None has been evaluated in a formal way. There is little information about how, and if, different requirements for caregivers

who provide child care for subsidized children protect their health and safety. We do not know whether background checks work better than self-certifications or whether required orientations that cover health and safety are more effective than required training that covers the same topics. Nor do we know which combinations of strategies—background checks, self-certification and training or self-certifications and orientations—reduce the incidence of harm to children or produce better health outcomes for them. As a result, we cannot determine whether the standards are too strict—disqualifying too many caregivers, thus limiting parent choice, or too lax—placing children at risk.

Our findings also show that a significant number of the states in our survey have created initiatives that are specifically designed for family, friend and neighbor caregivers. Many of the efforts are in states with large proportions of subsidized children in these arrangements, because, as more than one state administrator indicated, "That's where our children are." Most are relatively new attempts to improve the quality of license-exempt child care.

Like the subsidy requirements, the initiatives for caregivers who provide child care for subsidized children also have a health and safety focus. All of the training and professional development workshops include sessions on these aspects of child care; health and safety equipment predominates among the materials that are distributed to caregivers. Most of the technical assistance initiatives focus on these issues as well. In some cases, state administrators acknowledge that they are intended to serve as "another set of eyes" on this population of caregivers.

Here, too, we do not have much evaluation data about the initiatives, although there is some information about participation rates and caregiver satisfaction with services. Without firm evidence, we cannot assess the strengths and weaknesses of different recruitment strategies and program designs, or the impact of different strategies on caregivers' practices. As a result, policy makers lack crucial information to guide decisions about future directions for efforts to support kith and kin caregivers.

Our research raises some broad questions about state policies for family, friend and neighbor care in general. One is related to the anticipated long-term outcomes of these efforts. Are they intended to reduce the incidence of illness, accidents and harm among children or to improve children's readiness for school? If the former is the objective, there is a serious need for evidence about the effectiveness of different strategies to obtain these results. If the latter is the goal, greater attention should be paid to topics that that can help caregivers understand how to support cognitive, language, and social-emotional development, all of which are related to later school success.

Another question is related to the blurred distinction between license-exempt caregivers and regulated family child care providers in regulatory systems. As we noted earlier, the same caregivers may be exempt from licensing in one state and subject to it in another. This fuzziness extends to requirements for participation in the subsidy system and to requirements for training as well. In some states, license-exempt caregivers must comply with the same requirements as regulated family child care providers to provide care for subsidized children (Dan Lesser, personal communication, October 5, 2004). In others, license-exempt caregivers in the subsidy system must complete almost the same number of training hours as their regulated family child care provider counterparts. In still others, the number of hours offered by special training initiatives for license-exempt caregivers is comparable to the number of hours that the states require for in-service training for regulated family child care providers (National Child Care Information Center, 2004). Given these similarities, what is the purpose of creating two different categories of care that is offered in the provider's home?

A third question is related to the rationale for initiatives for family, friend and neighbor caregivers. If the regulatory and programmatic distinctions between home-based caregivers who are licensed and those who are not are so blurred, why develop special initiatives for license-exempt caregivers at all? Instead, it might make more sense to integrate kith and kin caregivers in system-wide efforts to improve child care quality. This approach would have several

advantages. On the one hand, it would ensure that all providers—those who are license-exempt as well as those who are part of the regulatory system—would have the same opportunities to gain knowledge and skills On the other, it would provide access to professional development for those kith and kin caregivers who come to see child care as their profession.

Before such an strategy is implemented, however, there is a need for systematic examination of several fundamental questions. Which approaches work best with license-exempt caregivers? What are the differences, if any, between these approaches and those that work best with regulated family child care providers? What kinds of changes, if any, would be required to integrate family, friend and neighbor caregivers into system-wide efforts to improve quality? Finding answers to these questions seems like an important item for the family, friend and neighbor care policy agenda.

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Appendix A:
State Definitions of License-Exempt Child Care

State	Definition
Alabama	**Relatives** including those related by blood marriage, and adoption; parents, grandparents, siblings, step-parents, step-grandparents, step-siblings, half-siblings, aunts, uncles, and spouses. **Non-relatives** must be licensed if caring for a child for more than 4 hours/week.
Alaska	**Relatives** related by blood, marriage, or adoption (an unlimited number of children). **Non-relatives** caring for 4 or fewer children.
Arizona	**Relatives. Non-Relatives** caring for 4 or fewer children.
Arkansas	**Relatives** if caring only for related children. **Non-relatives** caring for 5 or fewer children for more than 10 hours/week or more than 5 hours/day for payment.
California	**Relatives** defined as grandparents, aunts, and uncles. **Non-relatives (and relatives)** caring for unlimited number of children from same family.
Colorado	**Relatives** are defined as siblings, uncles, aunts, first cousins, nephews, nieces, grandparents, great-grandparents, or great-great-great-grandparents by blood, marriage or adoption, including exes. **Non-relatives (and relatives)** who are caring for 1 child for less than 24 hours or 2 children from the same family for less than 24 hours.
Connecticut	**Relatives** related by blood, marriage and adoption. **Non-relatives** providing care in the child's home without a time restriction in the length of care other than the parent(s)' work schedule, or providing care in the non-relative provider's home for less than 3 hours/day. In either case, the caregiver may provide full time care for only 3 children under the age of two, or as many as 6 children as long as only 2 of them are under the age of two.
Delaware	**Relatives only**. For reimbursement, caring for no more than 2 children under 2 years and a maximum of 5 children including caregiver's own.
Florida	**Relatives. Non-relatives** caring for children from one related family.
Georgia	**Relatives only**, defined as aunts, uncles, grandparents, and great-grandparents.
Hawaii	**Relatives** including those related by blood, marriage, or adoption. **Non-relatives** caring for 2 or fewer children.
Idaho	**Relatives and non-relatives** caring for 6 or fewer children.
Illinois	**Relatives and non-relatives** caring for 3 or fewer children including their own children or an unlimited number of children if they are from the same family.
Indiana	**Relatives and non-relatives** caring for 5 or fewer children.
Iowa	**Relatives and non-relatives** caring for 5 or fewer children (voluntary registration). Anyone caring for six or more children must be registered.
Kansas	**Relatives** caring for children for less than 20 hours/week. **Non-relatives** caring for only one child, for less than 20 hours/week.
Kentucky	**Relatives. Non-relatives** caring for 3 or fewer children.
Louisiana	**Relatives and non-relatives** who care for 6 or fewer children must be registered. Caregivers caring for 7 or more children must be licensed.
Maine	**Relatives. Non-relatives** caring for 2 or fewer non-related children.
Maryland	**Relatives** defined as siblings, step-siblings, first and second cousins, uncle, aunt, great-aunt, great-uncle, niece/nephew, grandparent or great-grandparent. **Non-relatives** caring for children for 20 hours or less.

State	Definition
Massachusetts	**Relatives** defined as parents, grandparents, great-grandparents, adult siblings not living in caregiver's home, aunts, and uncles. **Non-relatives** if caring for child in the child's home.
Michigan	**Relatives** related by blood, marriage or adoption caring for 5 or fewer children in including caregiver's own. **Non-relatives** who have been on federal land for less than 4 weeks or if the child's parent is present.
Minnesota	**Relatives** defined as aunts, uncles, grandparents. **Non-relatives** caring for one family other than caregiver's own with no limit on the number of children.
Mississippi	**Relatives and non-relatives** caring for 5 or fewer children.
Missouri	All caregivers must be registered to be reimbursed. **Relatives** exempt from licensure. **Non-relatives** exempt from licensure if caring for 4 or fewer children.
Montana	**Relatives and non-relatives** caring for 2 or fewer children or caring for children from one family.
Nebraska	**Relatives and non-relatives** caring for 3 or fewer children or caring for children from one family.
Nevada	**Relatives** defined as grandparents, aunts, uncles, aunts and uncles once-removed, and first cousins. **Non-relatives** in rural areas caring for 4 or fewer children. **Non-relatives** in Washoe County caring for 1 child. **Non-relatives** in Las Vegas and Clarke County must be licensed.
New Hampshire	**Relatives. Non-relatives** caring for 3 or fewer unrelated children, in addition to their own.
New Jersey	**Relatives** related by blood, marriage, and adoption. **Non-relatives** caring for 4 or fewer children. Non-relatives must be approved for reimbursement.
New Mexico	All caregivers must be registered to be reimbursed. **Relatives** exempt from licensure. **Non-relatives** must be registered if caring for 4 or fewer children excluding their own. **Non-relatives** must be certified if caring for 6 or fewer children, including caregiver's own children.
New York	**Relatives** related up to third degree of consanguinity. **Non-relatives** caring for 3 or fewer children or less than 3 hours/day.
North Carolina	**Relatives** related by blood, marriage or adoption. **Non-relatives** may care for a maximum of two children.
North Dakota	**Relatives** parents, grandparents, great-grandparents, adult siblings not living in caregiver's home, aunts, and uncles. **Non-relatives** caring for 5 or fewer children.
Ohio	**Relatives and non-relatives** caring for 5 or fewer children**.**
Oklahoma	**Relatives** defined as parents, grandparents, siblings, step-parents, step-siblings, uncles, aunts and cousins. **Non-relatives** caring for children for less than 15 hours/week.
Oregon	**Relatives** related by blood to the fourth degree. **Non-relatives** caring for 3 or fewer children or children from one family for no more than 70 hours/year.
Pennsylvania	**Relatives** defined as aunts, uncles, and grandparents. **Non-relatives** caring for 3 or fewer children.
Rhode Island	**Relatives** caring for 6 or fewer children to qualify for reimbursement. **Non-relatives** caring for 3 or fewer children.
South Carolina	**Relatives. Non-relatives** caring for 5 or fewer children from a maximum of 2 different families.
South Dakota	**Relatives. Non-relatives** caring for 12 or fewer children from one family.
Tennessee	

State	Definition
Texas	**Relatives only** defined as parents, grandparents, great-grandparents, adult siblings not living in caregiver's home, aunts, and uncles by blood, marriage, relationship or court decree.
Utah	**Relatives only.** Definition includes grandparents, step-grandparents, ex-grandparents, aunts and uncles, step-aunts and step-uncles, ex-aunts and ex-uncles.
Vermont	
Virginia	**Relatives only.**
Washington	**Relatives only.** Relatives are defined as grandparents, aunts, uncles, great-aunts and great-uncles, adult siblings. Non-relatives if caring for children in the child's homes. Relatives and non-relatives can receive payment if caring for 6 or fewer children at one time.
West Virginia	**Relatives and non-relatives** caring for 3 or fewer children.
Wisconsin	**Relatives and non-relatives** caring for 3 or fewer children.
Wyoming	**Relatives** defined as grandparents, great-grandparents, aunts, uncles, adult siblings. **Non-relatives** caring for 1 unrelated child.