LOCATE: CHILD CARE
FAMILY CHILD CARE QUESTIONNAIRE

Instructions: Please answer the following questions regarding your family child care home. If there is information you do not wish to share or you feel does not apply to you, please indicate with a "NR" (not relevant) in the space provided. If you have any questions or concerns about the questionnaire, feel free to call the LOCATE staff at 410.659.7701 x230. Please return the completed questionnaire by mail to Maryland Family Network, 1001 Eastern Ave. Fl 2, Baltimore, Maryland 21202. Or, you can fax the completed form to 410.385.0561.

PLEASE TYPE OR PRINT

Date _______________________

1. Name _____________________________________________________________

2. Site Address __________________________ Community/Development _______________________

3. City __________________________ 4. County __________________________

5. Zip __________________________ 6. Landline Phone __________________________

7. Mailing Address (if different from site address) __________________________
   Cell Phone __________________________
   Fax __________________________
   E-mail __________________________

Website Address __________________________________________

8. Are you interested in receiving occasional emails from Maryland Family Network concerning child care and family issues? Yes No

9. Please circle all that apply:
   There is a subway/light rail station near my home. Yes No
   Name of subway/light rail station __________________________________________
   There is a public bus line near my home. Yes No
   Bus names and numbers __________________________________________

10. We are very interested in linking child care providers with the closest public school that the children you care for attend. If you had to choose one school, what is your primary public elementary school and your primary public middle school? (Please answer even if you do not provide school-age care).
   a. Primary public elementary school __________________________________________
      Name of public/private elementary schools that you transport to/from __________________________
   b. Primary public middle school __________________________________________
      Name of public/private middle schools that you transport to/from __________________________
   c. Other schools (public or private) you would like to list __________________________

11. a. Please circle all that you provide:
   Before and/or after elementary school care Yes No
   Before and/or after middle school care Yes No
   Before and/or after preschool program (nursery, public pre-kindergarten, part-day, Head Start and Early Head Start) Yes No
b. Please circle all that apply if you offer any before and/or after school care:

<table>
<thead>
<tr>
<th>I can walk/drive children to/from:</th>
<th>school</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>school bus stop</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Children can walk to/from:</td>
<td>school</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>school bus stop</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>


b. Are you willing to adjust the opening and closing hour to accommodate a parent's needs? Yes No

13. Please check the days of the week that you are regularly open:

   Sun ____  Mon ____  Tues ____  Wed ____  Thurs ____  Fri ____  Sat ____

14. Please circle your answers:

   a. Accept income eligible children who are paid for by the Department of Social Services (Child Care Subsidy) Yes No

   b. Provide discount when caring for more than one child from the same family (Sibling Discount) Yes No

   c. Offer sliding fee (fee that is flexible according to the parent's income) Yes No

15. a. Do you offer care:  _____ Full time?  _____ Part-time?  _____ Both?

b. Do you offer infant care:  _____ Full time?  _____ Part-time?  _____ Both?

16. Are you open:

   _____ 9 or 10 months (closed in summer)  _____ 12 months (year-round)

   _____ Summer only  _____ During school vacations

17. Please circle yes or no for each of the following schedules. (Please send a copy of your license if you offer evening or overnight care. This must be reflected on your license). Do you offer:

<table>
<thead>
<tr>
<th>Weekend (on regular basis)</th>
<th>Yes</th>
<th>No</th>
<th>Temporary/emergency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop-in care</td>
<td>Yes</td>
<td>No</td>
<td>Overnight</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Evening</td>
<td>Yes</td>
<td>No</td>
<td>Rotating schedule</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

18. a. Do you require that all children be toilet trained except where a disability prevents toilet training? Yes No

b. Will you toilet train or assist with toilet training toddlers except where a disability prevents toilet training? Yes No

c. Will you administer prescribed medication with written permission? Yes No

19. Do you speak more than one language fluently? Yes No

   If yes, which language(s): ____________________________________________________________________________
20. Please check all that apply to your home:

   _____ Apartment/condo   _____ Trailer   _____ Fenced yard
   _____ Townhouse   _____ Duplex   _____ Swimming pool
   _____ Single family home

   _____ Totally smoke-free environment
   or   _____ Smoke-free during child care hours
   or   _____ Smoke outside during child care hours

21. Please check any pets in the home or check “No Pets.” Check all that apply.

   _____ No pets in home   _____ Ferret
   _____ Dog   _____ Mice, gerbils, etc.
   _____ Cat   _____ Hamster   _____ Bird
   _____ Fish   _____ Guinea Pig   _____ Snake
   _____ Other ___________________________

22. Please check the meals that you provide:

   _____ Breakfast   _____ P.M. snack
   _____ A.M. snack   _____ Dinner
   _____ Lunch   _____ No meals/snacks

23. Does your household accommodate special diets (ex: kosher, vegetarian, severe food allergies)?

   Yes   No   If yes, which ones? __________________________________________________________

ENROLLMENT INFORMATION

Would you please take a few extra moments to complete the following questions concerning the enrollments in your program? This information, combined with that of other caregivers, will be used to provide an accurate picture of the number of children currently enrolled in regulated child care in Maryland.

24. How many children 6 weeks through 23 months old do you have currently enrolled in your program? ______

25. How many children ages 2 years through 4 years old do you have currently enrolled in your program? ______

26. Do you have 5 year olds* enrolled in your program all day, all year?

   *These are the 5 year olds who did not make the September 1st kindergarten age cutoff.

   Yes _____   If yes, how many? ____________   No __

27. Do you have school age children*, kindergarten and up, in your program? (i.e., before/after school, and/or summer and holidays) *These are the 5 year olds who made the September 1st kindergarten age cutoff.

   Yes _____   If yes, how many? ____________   No __
DEPOSITS, FEES AND ADDITIONAL INFORMATION

28. Please circle Y if your program accepts or N if your program does not accept children of each age. Then complete the chart by listing the fees you charge for the different age groups that you accept.

<table>
<thead>
<tr>
<th>AGE</th>
<th>ACCEPT</th>
<th>WEEKLY COST FOR FULL-TIME CARE</th>
<th>DAILY COST FOR PART-TIME CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 wks. - 11 mon.</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>12 mon. - 23 mon.</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>2 years</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>3 years</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>4 years</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>5 years and older (full time during holidays/summer)</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>Before/after preschool</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>Before/after school (5 and older)</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per day</td>
</tr>
</tbody>
</table>

Please complete the following chart if you provide evening/overnight care (as reflected on your license) or weekend care. If you do not provide care during these hours, skip to question 28.

<table>
<thead>
<tr>
<th>AGE</th>
<th>ACCEPT</th>
<th>WEEKLY COST FOR EVENING CARE</th>
<th>WEEKLY COST FOR OVERNIGHT CARE</th>
<th>DAILY COST FOR WEEKEND CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 wks. - 11 mon.</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>12 mon. - 23 mon.</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>2 years</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>3 years</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>4 years</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per week</td>
<td>$_____ per day</td>
</tr>
<tr>
<td>5 years and older</td>
<td>Y N</td>
<td>$________ per week</td>
<td>$_____ per week</td>
<td>$_____ per day</td>
</tr>
</tbody>
</table>

29. Do you require a security deposit?  Yes ____  If yes, how much? $_________  No ____

30. Do you require a registration fee?  Yes ____  If yes, how much? $_________  No ____

31. Provide care for up to what age?  ______ years

32. Are you part of the Child and Adult Care Food Program?  Yes  No

33. Are you a member of your local family child care provider association?  Yes  No

34. Do you have Internet access?  Yes  No

35. Do children have access to a computer in your child care program?  Yes  No

36. Do children have access to the Internet in your child care program?  Yes  No
The information you provide for Questions 35-41 is for statistical purposes only and will not be available as part of your referral information to parents. Your information is combined with the information of other caregivers in order to study trends in the areas of compensation and benefits.

37. a. What is the current estimated gross income from your business?  
   (Indicate your answer on the basis of weekly income or monthly income, whichever is easier):  
   Weekly $ ____________ or Monthly $ ____________

   b. Which of the following benefits do you have? (Check all that apply).

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Yes, Paid by Your Family Child Care Business</th>
<th>Yes, Through Spouse</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Specify: ______________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SPECIAL NEEDS CARE

38. Do you currently have a child or children with special needs or disabilities enrolled in care?  
   Yes ______ If yes, how many? ____________ No ______

39. Do you currently have a child or children in care who are receiving early childhood mental health services or behavioral consultation services?  
   Yes ______ If yes, how many? ____________ No ______ Don’t know ______

40. Please check the name of the project below from which you may have received behavioral consultation services:  
   __ Apples for Children (Western Maryland)  
   __ Arundel Child Care Connections (Anne Arundel)  
   __ Project Act (Baltimore, Harford and Cecil Counties)  
   __ CARE Center, Howard County Office of Children’s Services  
   __ Montgomery County Early Childhood Mental Health Consultation Service  
   __ Partnerships for Emotionally Resilient Kids (PERKS) (Frederick & Carroll Counties)  
   __ Project First Choice (Southern Maryland)  
   __ Project Right Steps & Project Right Steps Plus (Upper Shore)  
   __ Project WIN (Wise Intervention Now) (Prince Georges County)  
   __ The Early Intervention Project (Baltimore City Child Care Resource Center)  
   __ The Lower Shore Early Intervention Program at the Lower Shore Child Care Resource Center  
   __ Did not receive any behavioral consultation services.
41. Do you currently have a child or children in care who are receiving early intervention services from Infant and Toddlers or Child Find other than mental health services?
   - Yes  
   - If yes, how many?  
   - No  
   - Don’t know

42. Have you ever referred a child or children for early intervention services?
   - Yes  
   - If yes, how many?  
   - No  
   - Don’t know

43. Did you terminate the care of a child due to behavior problems between January 1, 2011 and December 31, 2011?
   - Yes  
   - If yes, how many?  
   - No

44. a. Have you had experience caring for children or adults with disabilities (child care, family and/or community activities)?
   - Yes  
   - No

b. If yes, please check which disabilities you have had experience with or knowledge of:

   **Cognitive**
   - Delayed Development
   - Down Syndrome
   - Fragile X
   - Learning Disabled
   - Intellectual Disability
   - Speech/Language Delay
   - Traumatic Brain Injury

   **Physical**
   - Arthritis
   - Cerebral Palsy
   - Hearing/Vision Loss
   - Low Muscle Tone
   - Muscular Dystrophy
   - Orthopedic
   - Paraplegic
   - Quadriplegic
   - Spina Bifida

   **Medical**
   - Apnea Monitor
   - BPD
   - Blood/Organ Disorder
   - Cancer
   - Colostomy Bags
   - Cystic Fibrosis
   - Diabetes
   - Drug Addicted/Exposed Newborns
   - Feeding Problems/GI Tubes
   - Genetic Disorder
   - George DeLange Syndrome
   - Heart Condition
   - HIV+/AIDS
   - Hydrocephalus
   - Lead Poisoning
   - Prematurity
   - Respiratory
   - Severe Allergies
   - Severe Asthma
   - Seizure Disorder
   - Trach Tube

   **Social/Emotional**
   - Adjustment Disorder
   - Asperger Syndrome
   - Attachment Disorder
   - ADD (Attention Deficit Disorder)
   - ADHD (Attention Deficit Hyperactivity Disorder)
   - Autism
   - Bipolar Disorder
   - Emotion Problems
   - Mood Disorder
   - Obsessive-Compulsive Disorder
   - ODD (Oppositional Defiant Disorder)
   - PDD (Pervasive Development Disorder)
   - Post-Traumatic Stress Disorder
   - Sensory Integration Dysfunction
   - Depression

c. Please circle all that apply to your program:
   - Currently wheelchair accessible (ramp or garage entry, etc.)
   - Working knowledge of sign language
EDUCATION

45. a. Check the highest level of education you have completed (check only one):
   _____ Less than High School   _____ Associate Degree   _____ Master Degree
   _____ GED/High School        _____ Bachelor Degree   _____ Doctoral Degree

   b. If you have an Associate Degree or higher, check your major area of study.
      _____ Child Development
      _____ Early Childhood Education
      _____ Elementary Education
      _____ Family Studies
      _____ Nursing
      _____ Psychology
      _____ Social Work
      _____ Special Education
      _____ Other_______________________

46. Have you completed college level credit courses in Child Development or Early Childhood Education?     ___ Yes   ___ No

47. Have you completed college level credit courses in Special Education?                              ___ Yes   ___ No

48. Do you have a teaching certificate in Special Education issued by Maryland State Department of Education? ___ Yes   ___ No

TRAINING

49. a. Do you have a 90 Hour Early Childhood Education Pre-service Certificate?   ___ Yes   ___ No
       b. Do you have a 45 Hour Infant and Toddler Pre-service Certificate?      ___ Yes   ___ No
       c. Do you have a 45 Hour School Age Pre-service Certificate?              ___ Yes   ___ No
       d. Do you have a 9 Hour Communication Pre-service Certificate?           ___ Yes   ___ No
       e. Do you have a 45 Hour Administrative Training Pre-Service Certificate? ___ Yes   ___ No

50. Have you taken Maryland Model For School Readiness (MMSR) training? ___ Yes   ___ No

51. Have you taken Medication Administration Training?     ___ Yes   ___ No

52. Please list any trainings you have taken relating specifically to care for children with disabilities.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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53. Do you have any medical training? ___ Yes ___ No  
    If yes, please describe the type of training, such as nursing assistant, practical nursing, hospital aide, etc.

54. Is there anything else you would like to share with parents about your program?