MARYLAND FAMILY NETWORK

LOCATE: CHILD CARE GROUP PROGRAM QUESTIONNAIRE

Instructions: Please complete a separate questionnaire for **each licensed program facility/site** which you operate. Follow all instructions carefully to insure accurate information is maintained on your facility and program. This questionnaire is for many different kinds of programs. If the question does **not** apply to you, indicate with a "NR" (not relevant) in the space provided. If you have any questions, please call the LOCATE staff at 410.659.7701 X 230. Return the completed questionnaire to Maryland Family Network, 1001 Eastern Ave., Fl 2, Baltimore, Maryland 21202.

PLEASE TYPE OR PRINT

Date____________________________

1. Name of facility/program ____
2. Site Address ______________________ Community/Development ______________________
3. City ______________________ 4. County ______________________
5. Zip ______________________ 6. Site Phone ______________________
7. Mailing Address (if different from site address) 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. Site Director ____

10. a. Please check all that describe your program:

______ child care center (provides care to 2-5 year olds)
______ infant program (provides care to children under 2 years old)
______ nursery school (preschool program approved by the MSDE)
______ kindergarten (private kindergarten approved by MSDE)
______ part-day program (part-time preschool program for 2, 3 or 4 year olds, licensed by OCC)
______ school-age program (kindergarten and school-age children)
______ full-time (accepts kindergarten and older school-age children for summer, school closings, and holidays)
  ______ before school
  ______ after school
______ summer program (offers summer care to kindergarten and older school-age children)
______ Head Start (government-funded preschool for low-income children, 2-5 years old)
______ Early Head Start (government-funded program for low-income pregnant women, infants and toddlers)

b. If you indicated that you offer a school-age program, please check all of the activities your program offers:

_______ Homework Help _______ Arts & Crafts _______ Community Service
_______ Sports & Recreation _______ Performing Arts _______ Computer Activities
_______ Tutoring _______ Ethnic/Cultural

11. Please circle all that apply:

a. There is a subway/light rail station near the center Yes No
Name of subway/light rail station ______________________________

b. There is a public bus line near the center Yes No
Bus names and numbers ______________________________

(For Office Use: Map/Coordinates _____________)

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12. 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 or charter elementary schools that you may transport to/from:

    ____

    b. Primary public middle school ______________________________

    Name of public, private or charter middle schools that you may transport to/from:

    ____

13. 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, 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:

Center staff will walk/drive children to/from:	school	Yes	No	school bus stop	Yes	No
Children can walk to/from:	school	Yes	No	school bus stop	Yes	No

14. a. What time do you open?________________ Close? ________________

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

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

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

16. a. Do you offer care: ________ Full time? ________ Part-time? ________ Both?

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

17. Are you open:

    ________ 9 or 10 months (closed in summer) ________ 12 months (year-round)
    ________ Summer only ________ During school vacations

18. 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:

Weekend (on regular basis)	Yes	No	Temporary/emergency	Yes	No
Drop-in care	Yes	No	Overnight	Yes	No
Evening	Yes	No	Rotating schedule	Yes	No

19. 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

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

21. Does anyone on your staff speak more than one language fluently? Yes No

    If yes, which language(s): ______________________________

22. Please check the meals that you provide:

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

23. Are you willing to accommodate a special diet for a child? Yes No

24. Due to concerns of severe food allergies, is your center/program a peanut/nut-free environment? Yes No

DEPOSITS, FEES AND ADDITIONAL INFORMATION:

25. 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.

AGE	ACCEPT	WEEKLY COST FOR FULL-TIME CARE	DAILY COST FOR PART-TIME CARE
6 wks. - 11 mon.	Y N	$________ per week	$_______ per day
12 mon. - 23 mon.	Y N	$________ per week	$_______ per day
2 years	Y N	$________ per week	$_______ per day
3 years	Y N	$________ per week	$_______ per day
4 years	Y N	$________ per week	$_______ per day
5 years (In child care full-time)	Y N	$________ per week	$_______ per day
5 years and older (full time during holidays/summer)	Y N	$________ per week	$_______ per day
Before/after preschool	Y N	$________ per week	$_______ per day
Before/after school (5 and older)	Y N	$________ per week	$_______ per day

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 27.

AGE	ACCEPT	WEEKLY COST FOR EVENING CARE	WEEKLY COST FOR OVERNIGHT CARE	DAILY COST FOR WEEKEND CARE
6 wks. - 11 mon.	Y N	$________ per week	$________ per week	$_______ per day
12 mon. - 23 mon.	Y N	$________ per week	$________ per week	$_______ per day
2 years	Y N	$________ per week	$________ per week	$_______ per day
3 years	Y N	$________ per week	$________ per week	$_______ per day
4 years	Y N	$________ per week	$________ per week	$_______ per day
5 years and older	Y N	$________ per week	$________ per week	$_______ per day

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26. If you have an MSDE/OCC-approved nursery school or private kindergarten, please provide your monthly fees here:

____

27. Please circle your answers:

a. Accept income eligible children who receive the Child Care Subsidy from the Department of Social Services? Yes No

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

c. Provide scholarships Yes No

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

28. Do you require a security deposit? Yes ____ If yes, how much? $ ______________ No _____

29. Do you require a registration fee? Yes ____ If yes, how much? $ ______________ No _____

30. Provide care for up to what age? _____________ years

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

32. Are you a member of your local center association? Yes No

33. Please check all that apply:

Actual Location of Center

______ College site
______ Employer site
______ Hospital
______ Religious site
______ Public school site
______ Elementary school
______ Middle school
______ High school
________ Private school site
________ Business/ Industrial Park
________ Public Housing
________ Freestanding building

Auspices/Sponsorship

________ National chain
________ Local chain
________ Private non-profit agency
________ Public agency
________ Non-profit religious organization
________ Proprietary (for profit)

34. Do you have reserved slots for parents of a particular company, organization, agency or school?

Yes No

If yes, please name: ____

b. Do you give priority of available slots to parents of a particular company, organization, agency or school?

Yes No

If yes, please name: ____

c. Do you offer a discount to the parents of any company, organization, agency or school?

Yes No

If yes, please name: ____

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The information you provide for Questions 35-40 are 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.

35. a. Please complete the following chart.

POSITION	NUMBER OF PAID STAFF	AVERAGE ANNUAL FULL-TIME GROSS SALARY	AVERAGE ANNUAL PART-TIME GROSS SALARY
Directors			
Teachers/Senior Staff			
Aides			
Other			
Total Staff			

b. Do you provide benefits? Yes No
If yes, please check the benefits you provide:

	FULLY PAID	PARTIALLY PAID	AVAILABLE BUT NO EMPLOYER CONTRIBUTION
Pre-Employment Costs (i.e. physical, FBI check)			
Health Insurance			
Dental Insurance			
Life Insurance			
Other (Specify): ___________________________			

SPECIAL NEEDS

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

37. 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 _____

38. 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 _____

39. Have you ever referred a child or children for early intervention services?
Yes ______ If yes, how many? _______________ No _____ Don't know _____

40. Did you terminate the care of a child due to behavior problems between January 1, 2014 and December 31, 2014?
Yes ______ If yes, how many? _______________ No _____

41. 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
_____Intellectual Disability
_____Learning Disability
_____Speech/Language Delay
_____Traumatic Brain Injury
_____Other________________

Physical

_____Arthritis
_____Cerebral Palsy
_____Hearing/Vision Loss
_____Limited Mobility (requires a wheelchair)
_____Low Muscle Tone
_____Muscular Dystrophy
_____Orthopedic
_____Spina Bifida
_____Other __________________

Medical

_____Apnea Monitor
_____BPD
_____Blood/Organ Disorder
_____Bowel Disorder
_____Cancer
_____Colostomy Bags
_____Cystic Fibrosis
_____Diabetes
_____Drug Addicted/ ExposedNewborns
_____Feeding Problems/ GI Tubes
_____Genetic Disorder
_____Other _________________
_____Heart Problems
_____HIV+/AIDS
_____Hydrocephalus
_____Lead Poisoning
_____Prematurity
_____Reflux
_____Respiratory
_____Severe Allergies
_____Severe Asthma
_____Seizure Disorder
_____Sickle Cell
_____Trach Tube

Social/Emotional

_____Adjustment Disorder
_____Attachment Disorder
_____ADD(Attention Deficit Disorder)
_____ADHD (Attention Deficit Hyperactivity Disorder)
______Autism Spectrum
______Behavior Problems
______Bipolar Disorder
______Depression
_____Emotional Problems
_____Mood Disorder
_____Obsessive-Compulsive Disorder
_____ODD (Oppositional Defiant Disorder
_____Post-Traumatic Stress Disorder
_____ Sensory Integration Dysfunction
_____Social Communication Disorder
_____Other _________________

c. Please circle all that apply to your program:

Currently wheelchair accessible (ex.: ramp or garage entry, etc.)	Yes	No
Working knowledge of sign language	Yes	No

EDUCATION

42. a. Please indicate the number of your staff who have completed the following levels of education:

________ Less than High School ________ Associate Degree________ Master Degree

________ GED/High School ________ Bachelor Degree ________ Doctoral Degree

b. If you have staff with Associate Degrees or higher, please check the major areas of study:

_____ Child Development
_____ Early Childhood Education
_____ Elementary Education
_____ Family Studies
_____ Nursing
_____ Psychology
_____ Social Work
_____ Special Education
_____ Other ____

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43. Has anyone on your staff completed college level credit courses in Child Development or Early Childhood Education?

Yes No

44. a. Has anyone on your staff completed college level credit courses in Special Education?

Yes No

b. Does anyone on your staff have a teaching certificate in Special Education issued by Maryland State Department of Education?

Yes No

TRAINING

45. Do you have staff who have completed any of the following certifications:

a. 90 Hour Early Childhood Education Pre-service Certificate ___ Yes ___ No
b. 45 Hour Infant and Toddler Pre-service Certificate ___ Yes ___ No
c. 45 Hour School Age Group Leader Certificate ___ Yes ___ No

46. Please list any trainings taken by your staff relating specifically to care for children with disabilities.

____

____

____

47. Does anyone on your staff have any type of training in the medical field? ___ Yes ___ No

If yes, please list the areas, such as nursing assistant, practical nurse, hospital or medical aide, etc.

____

____

____

48. Does your center follow any of the following State-approved curricula?

___ *InvestiGator-Club (ages 3, 4 & 5)*
___ *Frog Street Preschool (age 4)*
___ *Little Treasures (age 4)*
___ *DLM Early Childhood Express (ages 3 & 4)*
___ *Kinder Corner and Curiosity Corner (ages 4 & 5)*
___ *Creative Curriculum for Preschool (ages 3 & 4) and Family Child Care (ages 3, 4 & 5)*
___ None of the above

49. a. If you don't follow a State-approved curriculum, do you follow any pre-school curriculum? Yes No

b. If yes, what is the name of the curriculum that you follow?

____

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