



MARYLAND
FAMILY
NETWORK

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 x234. Please return the completed questionnaire by email to mmoyd@marylandfamilynetwork.org, 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 PRINT

Date _____

Name _____

License Number (for identification purposes only) _____

Do you participate in Maryland EXCELS? Yes No

Child Care Type: Family Child Care Home Large Family Child Care Home

Site Address _____ Community/Development _____

City _____ County _____

Zip _____ Landline Phone _____

Mailing Address (if different from site address) _____ Cell Phone _____

_____ Fax _____

_____ E-mail _____

FEES AND ADDITIONAL INFORMATION:

Please complete the following information for each age group served. Do not include discounts

AGE Group	Full Time (weekly)	Part-Time (weekly)	Before/After School (daily)	Drop-In (daily)	Evening (daily)	Overnight (daily)	Weekend (daily)
6 wks. – 11 mon.	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
12 mon. – 23 mon.	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2 years	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3 years	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
4 years	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
5 years	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
School-Age (5+)	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Do you charge a Security fee?	<input type="checkbox"/> No		<input type="checkbox"/> Per child <input type="checkbox"/> Per Family	Annually: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you charge a Registration fee:	<input type="checkbox"/> No		<input type="checkbox"/> Per child	Annually: <input type="checkbox"/> Yes <input type="checkbox"/> No			

			____ Per Family	
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____ I DO WANT my fees published ____ I DO NOT WANT my fees published on any website.

Name of person completing form & receiving PAU (Required) _____

E mail address to send PAU (Required) _____

1. 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 _____

2. 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 transport to/from _____

3. 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:

I can 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

4. 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

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

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

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

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

7. Are you open:

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

_____ Summer only _____ During school vacations

8. 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

9. a. Do you require children to be toilet trained? 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

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

If yes, which language(s): _____

11. Please check all that apply to your home:

_____ Apartment/condo _____ Trailer _____ Fenced yard

_____ Townhouse _____ Duplex _____ Swimming pool

_____ Single family home _____ Pets

_____ Totally smoke-free environment

or _____ Smoke-free during child care hours

12. Please check any pets in the home or check "No Pets." Check all that apply.

_____ No pets in home _____ Dog _____ Cat _____ Other

13. Please check the meals that you provide:

_____ Breakfast _____ P.M. snack

_____ A.M. snack _____ Dinner

_____ Lunch _____ No meals/snacks

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

15. Due to concerns of severe food allergies is your family child care home a peanut/nut free environment?
Yes No

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

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

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

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

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

The information you provide for questions 23-29 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.

21. 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).

	YES, PAID BY YOUR FAMILY CHILD CARE BUSINESS	YES, THROUGH ANOTHER SOURCE	NONE
Health Insurance			
Dental Insurance			
Life Insurance			
Other Specify: _____			

SPECIAL NEEDS CARE

22. Do you currently have a child or children with special needs or disabilities enrolled in care?

Yes _____ If yes, how many? _____ No ____

23. 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 ____

24. 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 ____

25. Have you ever referred a child or children for early intervention services?

Yes _____ If yes, how many? _____ No ____ Don't know ____

26. Did you terminate the care of a child due to behavior problems between January 1, 2017 and December 31, 2017?

Yes _____ If yes, how many? _____ No ____

27. a. Have you had experience caring for children or adults with disabilities (child care, family, used Behavioral Counseling Services and/or community activities)? Yes No

b. If yes, please check which disability(ies) you have had experience with or knowledge of:

Cognitive

Physical

- ____ Delayed Development
- ____ Down Syndrome
- ____ Fragile X
- ____ Intellectual Disability

- ____ Learning Disability
- ____ Speech/Language Delay
- ____ Traumatic Brain Injury
- ____ Other _____

- ____ Arthritis
- ____ Cerebral Palsy
- ____ Hearing/Vision Loss
- ____ Limited Mobility
(requires a wheelchair)

- ____ Low Muscle Tone
- ____ Muscular Dystrophy
- ____ Orthopedic
- ____ Spina Bifida
- ____ Other _____

Medical

Social/Emotional

- ____ Apnea Monitor
- ____ BPD
- ____ Blood/Organ Disorder
- ____ Bowel Disorder
- ____ Cancer
- ____ Colostomy Bags
- ____ Cystic Fibrosis
- ____ Diabetes
- ____ Drug Addicted/
Exposed Newborns
- ____ 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

- ____ 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

c. Please circle all that apply to your program:

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

EDUCATION

28. 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 _____

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

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

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

TRAINING

32. 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

33. Have you taken Medication Administration Training? Yes No

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

35. 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.

36. Do you follow any of the following State-approved curricula?

- Frog Street (ages 3 & 4)
- DLM EC Express (ages 3 & 4)
- Little Treasures (age 4)
- Investigator Club (ages 3, 4, & 5)
- Curiosity Corner and Kinder Corner (ages 4 & 5)
- Creative Curriculum for Family Child Care (ages 3, 4, & 5)
- Creative Curriculum (ages 3 & 4)
- Connect 4 Learning (age 4)
- OWL Opening the World of Learning
- None of the above

37. 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?

38. Do you have CDA accreditation? Yes No If Yes, please send documentation with this form.