MARYLAND FAMILY NETWORK

LOCATE: CHILD CARE
GROUP PROGRAM QUESTIONNAIRE

MARYLAND CHILDCARE RESOURCE NETWORK

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 234. Return the completed questionnaire to Maryland Family Network, 1001 Eastern Ave., Fl 2, Baltimore, Maryland 21202.

PLEASE PRINT

Date _____

Name _____

License Number (for identification purposes only) _____

Do you participate in Maryland EXCELS? _____Yes _____No

Child Care Type: _____ Child Care Center _____ Letter of Compliance Facility

Site Address _____ Director _____

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?	_____No		_____ Per child _____ Per Family		Annually: _____Yes _____No		
Do you charge a Registration fee:	_____No		_____Per child _____Per Family		Annually: _____Yes _____No		

_____ **I DO WANT** my fees published _____ **I DO NOT WANT** my fees published on any website.

(For Office Use: Map/Coordinates _____)

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

E mail address to send PAU (Required) _____

1. . 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)

2. 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 _____

3. 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:

_____

4. 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

5. 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

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

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

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

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

8. Are you open:

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

9. Please circle yes or no for each of the following schedules. (Please send a copy of your license if you offer **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
Rotating schedule	Yes	No			

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

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

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

If yes, which language(s): _____

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 center/program a peanut/nut-free environment? Yes No

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

_____

17. 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

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

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

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

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

22. Please check all that apply:

Actual Location of Center		**Auspices/Sponsorship**
_____ College site	_____ Private school site	_____ National chain
_____ Employer site	_____ Business/ Industrial Park	_____ Local chain
_____ Hospital	_____ Public Housing	_____ Private non-profit agency
_____ Religious site	_____ Freestanding building	_____ Public agency
_____ Public school site		_____ Non-profit religious organization
_____ Elementary school		_____ Proprietary (for profit)
_____ Middle school		
_____ High school		

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

Yes No

If yes, please name the organization: _____

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: _____

The information you provide for Questions 25- 32 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.

24. 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

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

Yes _____ If yes, how many? _____ No _____

26. 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 _____

27. 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 _____

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

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

29. Have you ever referred a child or children to a behavior consultant?

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

30. 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 _____

31. 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

32. 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 _____

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

Yes No

34. 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

35. 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

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

_____

_____

_____

37. 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.

_____

_____

_____

38. 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)*
___ *Creative Curriculum for Family Child Care (ages 3, 4 & 5)*
___ None of the above

39. 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?

_____