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 ____________________________________________

Site Address ________________________________________ Community/Development ____________________________

City ____________________________ County ____________________________

Zip ____________________________ Landline Phone ____________________________

Mailing Address (if different from site address) ____________________________

Cell Phone ____________________________ Fax ____________________________

E-mail ____________________________

Website Address ____________________________

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

FEES AND ADDITIONAL INFORMATION

16. 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. We use this information for data reporting purposes. If you do not want us to share your fees, please indicate below.

   May we share your fees with parents?  Yes  No

<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 (In child care full-time)</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>

17. 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 18.

<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>
18. 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

19. Do you require a security deposit?  Yes ___  If yes, how much? $  _________  No ___
20. Do you require a registration fee?  Yes ___  If yes, how much? $  _________  No ___
21. Are you part of the Child and Adult Care Food Program?  Yes  No
22. 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.

23. 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 ANOTHER SOURCE</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

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

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

26. 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 ______ No ______ Don’t know ______
   If yes, how many? ________

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

28. Did you terminate the care of a child due to behavior problems between January 1, 2017 and December 31, 2017?
   Yes ______ No ______
   If yes, how many? ________

29. 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
   ______ 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
   ______ Blood/Organ Disorder
   ______ Bowel Disorder
   ______ Cancer
   ______ Colostomy Bags
   ______ Cystic Fibrosis
   ______ Diabetes
   ______ Drug Addicted/
   ______ Exposed/Newborns
   ______ Feeding Problems/
   ______ GI Tubes
   ______ Genetic Disorder
   ______ Other

   Social/Emotional
   ______ Adjustment Disorder
   ______ ADD (Attention Deficit Disorder)
   ______ ADHD (Attention Deficit Hyperactivity Disorder)
   ______ Autism Spectrum
   ______ 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

30. 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____________________________________

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

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

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

TRAINING

34. 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

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

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

________________________________________________________

________________________________________________________

37. 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.
38. 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

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?

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