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

PLEASE TYPE OR PRINT

Name of facility/program ____________________________________________

Site Address ____________________________________________ Community/Development ____________________________________________

City ____________________________

County ____________________________

Zip ____________________________

Site Phone ____________________________

Mailing Address (if different from site address) ____________________________ Fax ____________________________

________________________________________ E-mail ____________________________

Website Address: ____________________________________________

Site Director ____________________________________________

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)

(For Office Use: Map/Coordinates ________ ) ©Maryland Family Network, 2018 02-2018
2. Please circle all that apply:
   a. There is a subway/light rail station near the center
      Name of subway/light rail station ________________________________ Yes No
   b. There is a public bus line near the center
      Bus names and numbers __________________________________________ Yes No

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. a. Do you require children to be toilet trained? Yes No
    If no, 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
- A.M. snack
- Lunch
- P.M. snack
- Dinner
- 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

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.

<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>

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.

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

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. Provide scholarships Yes No
   d. 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 center association? Yes No

23. 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

   **Auspices/Sponsorship**
   - Business/Industrial Park
   - Public Housing
   - Freestanding building
   - National chain
   - Local chain
   - Private non-profit agency
   - Public agency
   - Non-profit religious organization
   - Proprietary (for profit)

24. 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.

25. a. Please complete the following chart.

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NUMBER OF PAID STAFF</th>
<th>AVERAGE ANNUAL FULL-TIME GROSS SALARY</th>
<th>AVERAGE ANNUAL PART-TIME GROSS SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teachers/Senior Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. Do you provide benefits?  Yes  No

If yes, please check the benefits you provide:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>FULLY PAID</th>
<th>PARTIALLY PAID</th>
<th>AVAILABLE BUT NO EMPLOYER CONTRIBUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Employment Costs (i.e. physical, FBI check)</td>
<td></td>
<td></td>
<td></td>
</tr>
<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

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

27. 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

28. 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

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

30. Have you ever referred a child or children to a behavior consultant?
   Yes  If yes, how many?  No  Don’t know

31. 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
32. **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:

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Physical</th>
<th>Social/Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Development</td>
<td>Learning Disability</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Down Syndrome</td>
<td>Speech/Language Delay</td>
<td>Cerebral Palsy</td>
</tr>
<tr>
<td>Fragile X</td>
<td>Traumatic Brain Injury</td>
<td>Hearing/Vision Loss</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>Other</td>
<td>Limited Mobility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(requires a wheelchair)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical</th>
<th>Social/Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apnea Monitor</td>
<td>Adjustment Disorder</td>
</tr>
<tr>
<td>BPD</td>
<td>Attachment Disorder</td>
</tr>
<tr>
<td>Blood/Organ Disorder</td>
<td>ADD (Attention Deficit Disorder)</td>
</tr>
<tr>
<td>Bowel Disorder</td>
<td>ADHD (Attention Deficit Hyperactivity Disorder)</td>
</tr>
<tr>
<td>Cancer</td>
<td>Autism Spectrum</td>
</tr>
<tr>
<td>Colostomy Bags</td>
<td>Behavior Problems</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Depression</td>
</tr>
<tr>
<td>Drug Addicted/ExposedNewborns</td>
<td>Mood Disorder</td>
</tr>
<tr>
<td>Feeding Problems/ GI Tubes</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td></td>
<td>Defiant Disorder</td>
</tr>
<tr>
<td></td>
<td>Post-Traumatic Stress</td>
</tr>
<tr>
<td></td>
<td>Sensory Integration</td>
</tr>
<tr>
<td></td>
<td>Social Dysfunction</td>
</tr>
<tr>
<td></td>
<td>Social Communication</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**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**

33. **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
34. Has anyone on your staff completed college level credit courses in Child Development or Early Childhood Education?
   Yes  No

35. 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**
36. 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

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

______________________________________________________________________________________________

______________________________________________________________________________________________

38. 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.

______________________________________________________________________________________________

______________________________________________________________________________________________

39. 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

40. 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?

______________________________________________________________________________________________