MARYLAND FAMILY NETWORK

LOCATE: CHILD CARE
FAMILY CHILD CARE QUESTIONNAIRE

MARYLAND CHILDCARE RESOURCE NETWORK

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
_____ 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 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

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

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.

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

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).

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

SPECIAL NEEDS CARE

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

Yes _____ If yes, how many? _____ No ____

25. 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 ___

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

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

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

28. 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 ____

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
_____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

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.

