

for child care
providers



Instructions for Completing Questionnaire

If you have not updated your LOCATE record in the past year, please print out the questionnaire and complete it. Please print clearly.

After completing it, you can fax it or scan and email it to the child care resource center in your area. The contact information is listed below. A LOCATE: Child Care counselor will contact you if there are any questions about the information you provided.

If you prefer, you can call your local resource center and complete the questionnaire over the telephone with the LOCATE staff. Click [here](#) for the list of center telephone numbers.

<u>County</u>	<u>Fax Number</u>	<u>Email Address</u>
Allegany	301-733-0886	sdowdy@applesforchildren.org
Anne Arundel	410-222-1723	welcome@arundelccc.org
Baltimore City	410-685-2100	childcare@bccrc.org
Baltimore County	410-288-3943	info@childcarelinksinc.org
Calvert	301-290-0050	info@smccrc.org
Caroline	410-827-7121	ccrc@chesapeake.edu
Carroll	301-695-4826	childcarechoices@fcmha.org
Cecil	443-512-0185	mkilczewski@hcchildcarelinksinc.org
Charles	301-290-0050	info@smccrc.org
Dorchester	410-827-7121	ccrc@chesapeake.edu
Frederick	301-695-4826	childcarechoices@fcmha.org
Garrett	301-733-0886	Sdowdy@applesforchildren.org
Harford	443-512-0185	mkilczewski@hcchildcarelinksinc.org
Howard	410-313-1430	childcare@howardcountymd.gov
Kent	410-827-7121	ccrc@chesapeake.edu
Montgomery	301-279-1812	earlychildhoodservices@montgomerycountymd.gov
Prince George's	301-772-8410	lterrell@pgcrc.org
Queen Anne's	410-827-7121	ccrc@chesapeake.edu
St, Mary's	301-290-0050	info@smccrc.org
Somerset	410-543-6655	kayungel@salisbury.edu
Talbot	410-827-7121	ccrc@chesapeake.edu
Washington	301-733-0886	Sdowdy@applesforchildren.org
Wicomico	410-543-6655	kayungel@salisbury.edu
Worcester	410-543-6655	kayungel@salisbury.edu

ANNUAL 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 your local child care resource center.

PLEASE TYPE OR PRINT

Date _____

1. Name _____
2. Address _____ Community/Development _____
3. City _____ 4. County _____
5. Zip _____ 6. Phone () _____
7. Mailing Address (if different from site address) Fax () _____
- _____ E-mail _____
- _____

Website Address: _____

8. 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 _____

9. 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 elementary schools that you transport to/from _____

b. Primary public middle school _____

Name of public/private middle schools that you transport to/from _____

c. Other schools (public or private) you would like to list _____

10. 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 |

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11. 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

12. Please check the days of the week that you are regularly open:
 Sun____ Mon____ Tues____ Wed____ Thurs____ Fri____ Sat____

13. Please circle your answers:

- a. Accept income eligible children who are paid for by the Department of Social Services (Child Care Subsidy) 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

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

15. Are you open:
 9 or 10 months (closed in summer) _____ 12 months (year-round) _____
 Summer only _____ During school vacations _____

16. 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

17. a. Do you require that all children be toilet trained except where a disability prevents toilet training?
 Yes No
 b. Will you toilet train or assist with toilet training toddlers except where a disability prevents toilet training?
 Yes No

18. Please circle all that apply to your program:
 CPR trained Yes No
 First-Aid trained Yes No
 Administer prescribed medicine (with written permission) Yes No
 Speak more than one language fluently Yes No
 If yes, which language(s): _____

19. Please check all that apply to your home:

- | | | | |
|--------------------|-------|----------------------|-------|
| apartment/condo | _____ | fenced yard | _____ |
| townhouse | _____ | swimming pool | _____ |
| single family home | _____ | pets | _____ |
| trailer | _____ | <i>type of pets:</i> | _____ |
| duplex | _____ | | _____ |
- or totally smoke-free environment _____
 or smoke-free during child care hours _____
 or smoke outside during child care hours _____

Enrollment Information

Would you please take a few extra moments to complete the following questions concerning the enrollments in your program? This information, combined with that of other caregivers, will be used to provide an accurate picture of the number of children currently enrolled in regulated child care in Maryland.

20. How many children under 2 years of age do you have currently enrolled in your program? _____

21. How many children ages 2-4 years of age do you have currently enrolled in your program? _____

22. Do you have 5 year olds* enrolled in your program all day, all year?

**These are the 5 year olds who did not make the September 1st kindergarten age cutoff.*

Yes ___ If yes, how many? _____ No ___

23. Do you have school age children*, kindergarten and up, in your program? (i.e., before/after school, and/or summer and holidays) **These are the 5 year olds who made the September 1st kindergarten age cutoff.*

Yes ___ If yes, how many? _____ No ___

24. Please check the meals that you provide:

Breakfast	_____	P.M. snack	_____
A.M. snack	_____	Dinner	_____
Lunch	_____	No meals/snacks	_____

25. Does your household accommodate special diets (ex: kosher, vegetarian, severe food allergies)?

Yes No If yes, which ones? _____

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26. 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.

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

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.

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

Deposits, Fees and additional information:

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

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

29. Provide care for up to what age? _____ years

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

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

32. Does your program have an emergency preparedness plan? Yes No

33. Have you received formal emergency preparedness training for your program? Yes No

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The information you provide for Questions 34-41 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, children's mental health, and computer usage by the child care community.

34. 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 spouse	None
Health Insurance			
Dental Insurance			
Life Insurance			
Other Specify: _____			

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

Yes ____ If yes, how many? ____ No ____

36. Do you currently have a child or children in care who are receiving early childhood mental health services?

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

37. Do you currently have a child or children in care who are receiving early intervention services other than mental health services?

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

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

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

39. Have you ever had to terminate the care of a child due to behavior problems?

Yes ____ If yes, how many? ____ No ____

40. Do you have a working computer? ____ Yes ____ No

41. Do children have access to a computer in your child care program? ____ Yes ____ No

Special Needs Care

42. 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

Physical

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Speech/Language Delay | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Paraplegic |
| <input type="checkbox"/> Fragile X | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Hearing/Vision Loss | <input type="checkbox"/> Quadraplegic |
| <input type="checkbox"/> Learning Disabled | | <input type="checkbox"/> Low Muscle Tone | <input type="checkbox"/> Spina Bifida |
| | | <input type="checkbox"/> Muscular Dystrophy | |

Medical

Social//Emotional

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Apnea Monitor | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> BPD | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Blood/Organ Disorder | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Attachment Disorder | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> ODD (Oppositional Defiant Disorder) |
| <input type="checkbox"/> Colostomy Bags | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> PDD (Pervasive Development Disorder) |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Allergies | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Sensory Integration Dysfunction |
| <input type="checkbox"/> Drug Addicted/Exposed Newborns | <input type="checkbox"/> Severe Asthma | <input type="checkbox"/> Hyperactivity Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Feeding Problems/GI Tubes | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Autism | |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Trach Tube | <input type="checkbox"/> Behavior Problems | |
| <input type="checkbox"/> George DeLange Syndrome | | <input type="checkbox"/> Bipolar Disorder | |

c. Please circle all that apply to your program:
 currently wheelchair accessible Yes No
 know sign language Yes No

Education

43. 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

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

b. Do you have a college degree in Early Childhood Development or Early Childhood Education? Yes No

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

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

46. Is there anything else you would like to share with parents about your program, i.e. training, preschool activities offered, etc.?
