



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 x230. Please return the completed questionnaire to Maryland Family Network, 1001 Eastern Ave. Fl 2, Baltimore, Maryland 21202.

PLEASE TYPE OR PRINT

Date _____

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

Website Address: _____

8. Are you interested in receiving occasional emails from Maryland Family Network concerning child care and family issues? Yes No
9. 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 _____
10. 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 _____
11. 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 (<i>nursery, public pre-kindergarten, part-day, Head Start and Early Head Start</i>)	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

12. 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

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

Sun___ Mon___ Tues___ Wed___ Thurs___ Fri___ Sat___

14. 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

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

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

16. Are you open:

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

17. 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

18. 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

19. 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): _____

20. Please check all that apply to your home:

- | | |
|---|--|
| <input type="checkbox"/> Apartment/condo | <input type="checkbox"/> Fenced yard |
| <input type="checkbox"/> Townhouse | <input type="checkbox"/> Swimming pool |
| <input type="checkbox"/> Single family home | <input type="checkbox"/> Pets |
| <input type="checkbox"/> Trailer | <i>Type of pets:</i> _____ |
| <input type="checkbox"/> Duplex | _____ |
- 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.

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

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

23. 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 _____

24. 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 _____

25. Please check the meals that you provide:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Breakfast | <input type="checkbox"/> P.M. snack |
| <input type="checkbox"/> A.M. snack | <input type="checkbox"/> Dinner |
| <input type="checkbox"/> Lunch | <input type="checkbox"/> No meals/snacks |

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

Yes No If yes, which ones? _____

27. 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 28.

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

28. Do you require a security deposit? Yes ____ If yes, how much? \$ _____ No ____
29. Do you require a registration fee? Yes ____ If yes, how much? \$ _____ No ____
30. Provide care for up to what age? _____ years
31. Are you part of the Child and Adult Care Food Program? Yes No
32. Are you a member of your local family child care provider association? Yes No
33. Does your program have an emergency preparedness plan? Yes No
34. Have you received formal emergency preparedness training for your program? Yes No

The information you provide for Questions 35-41 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.

35. 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: _____			

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

Yes _____ If yes, how many? _____ No _____

37. 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 _____

38. Please check the name of the project below from which you may have received behavioral consultation services:

- Apples for Children (Western Maryland)
- Arundel Child Care Connections (Anne Arundel)
- Abilities Network (Baltimore County)
- CARE Center, Howard County Office of Children's Services
- Montgomery County Early Childhood Mental Health Consultation Service
- Partnerships for Emotionally Resilient kids (PERKS) (Frederick & Carroll Counties)
- Project First Choice (Southern Maryland)
- Project Right Steps & Project Right Steps Plus (Upper Shore)
- Project WIN (Wise Intervention Now) (Prince Georges County)
- The Early Intervention Project (Baltimore City Child Care Resource Center)
- The Lower Shore Early Intervention Program at the Lower Shore Child Care Resource Center
- Did not receive any behavioral consultation services.

39. 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 _____

40. Have you ever referred a child or children for early intervention services?
 Yes _____ If yes, how many? _____ No _____ Don't know _____
41. Have you ever had to terminate the care of a child due to behavior problems?
 Yes _____ If yes, how many? _____ No _____
42. Do you have a working computer? Yes No
43. Do children have access to a computer in your child care program? Yes No

SPECIAL NEEDS CARE

44. 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"/> Intellectual Disability | <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"/> Quadriplegic |
| <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 Hyperactivity Disorder | <input type="checkbox"/> PDD (Pervasive Development Disorder) |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Autism | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Allergies | <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Sensory Integration Dysfunction |
| <input type="checkbox"/> Drug Addicted/Exposed Newborns | <input type="checkbox"/> Severe Asthma | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Feeding Problems/ GI Tubes | <input type="checkbox"/> Seizure Disorder | | |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Trach Tube | | |
| <input type="checkbox"/> George DeLange Syndrome | | | |

c. Please circle all that apply to your program:

- | | | |
|---------------------------------|-----|----|
| Currently wheelchair accessible | Yes | No |
| Know sign language | Yes | No |

