



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

## PLEASE TYPE OR PRINT

Date \_\_\_\_\_

- 1. Name of facility/program \_\_\_\_\_
- 2. Address \_\_\_\_\_ Community/Development \_\_\_\_\_
- 3. City \_\_\_\_\_ 4. County \_\_\_\_\_
- 5. Zip \_\_\_\_\_ 6. Site 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. Site Director \_\_\_\_\_

- 10. a. 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)

- b. If you indicated that you offer a school-age program, please check all of the activities your program offers:
 

_____ Homework Help	_____ Arts & Crafts	_____ Community Service
_____ Sports & Recreation	_____ Performing Arts	_____ Computer Activities
_____ Tutoring	_____ Ethnic/Cultural	

11. Please circle all that apply:

- a. There is a subway/light rail station near the center Yes    No  
 Name of subway/light rail station \_\_\_\_\_
- b. There is a public bus line near the center Yes    No  
 Bus names and numbers \_\_\_\_\_

12. 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  
 \_\_\_\_\_

13. 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, 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

- |  |                 |     |    |  |
|--|-----------------|-----|----|--|
| 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 |  |

14. 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

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

Sun \_\_\_\_ Mon \_\_\_\_ Tues \_\_\_\_ Wed \_\_\_\_ Thurs \_\_\_\_ Fri \_\_\_\_ Sat \_\_\_\_

16. 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. Provide scholarships Yes    No
- d. Offer sliding fee (fee that is flexible according to the parent's income) Yes    No



28. 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 1<sup>st</sup> kindergarten age cutoff.  
 Yes \_\_\_\_\_ If yes, how many? \_\_\_\_\_ No \_\_\_\_\_

**DEPOSITS, FEES AND ADDITIONAL INFORMATION:**

29. 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

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

---

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 29.

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

30. Do you require a security deposit? Yes \_\_\_\_\_ If yes, how much? \$ \_\_\_\_\_ No \_\_\_\_\_
31. Do you require a registration fee? Yes \_\_\_\_\_ If yes, how much? \$ \_\_\_\_\_ No \_\_\_\_\_
32. Provide care for up to what age? \_\_\_\_\_ years

33. Are you part of the Child and Adult Care Food Program? Yes No
34. Do you have a working computer? Yes No
35. Do children have access to a computer in your child care program? Yes No

36. 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
- Private school site
- Business/ Industrial Park
- Public Housing
- Freestanding building

**Auspices/Sponsorship**

- National chain
- Local chain
- Private non-profit agency
- Public agency
- Non-profit religious organization
- Proprietary (for profit)

37. a. Do you have reserved slots for parents of a particular company, organization, agency or school?

Yes No

If yes, please name: \_\_\_\_\_

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 36-43 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.

38. a. Please complete the following chart.

POSITION	NUMBER OF PAID STAFF	AVERAGE ANNUAL FULL-TIME GROSS SALARY	AVERAGE ANNUAL PART-TIME GROSS SALARY
Directors			
Teachers/Senior Staff			
Aides			
Other			
Total Staff			

b. Do you provide benefits? Yes No

If yes, please check the benefits you provide:

	FULLY PAID	PARTIALLY PAID	AVAILABLE BUT NO EMPLOYER CONTRIBUTION
Pre-Employment Costs (i.e. physical, FBI check)			
Health Insurance			
Dental Insurance			
Life Insurance			
Other (Specify): _____			

**SPECIAL NEEDS**

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

Yes \_\_\_\_\_ If yes, how many? \_\_\_\_\_ No \_\_\_\_\_

40. 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 \_\_\_\_\_

41. 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.

42. 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
43. Have you ever referred a child or children for early intervention services?  
 Yes  If yes, how many? \_\_\_\_\_ No  Don't know
44. Did you terminate the care of a child due to behavior problems between July 1, 2010 through June 30, 2011?  
 Yes  If yes, how many? \_\_\_\_\_ No
45. 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:

- |   |  |   |   |
|---|--|---|---|
| <b>Cognitive</b>  |  | <b>Physical</b>   |   |
| <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                       |   |
| <b>Medical</b>  |  | <b>Social/Emotional</b>   |   |
| <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 (ex.: ramp or garage entry, etc.) Yes  No

Working knowledge of sign language Yes    No

**EDUCATION**

46. 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 \_\_\_\_\_

47. Has anyone on your staff completed college level credit courses in Child Development or Early Childhood Education?

Yes    No    If yes, how many staff? \_\_\_\_\_

48. a. Has anyone on your staff completed college level credit courses in Special Education?

Yes    No    If yes, how many staff? \_\_\_\_\_

b. Does anyone on your staff have a teaching certificate in Special Education issued by Maryland State Department of Education?

Yes    No    If yes, how many staff? \_\_\_\_\_

**TRAINING**

49. 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 Pre-service Certificate    \_\_\_Yes \_\_\_No  
d. 9 Hour Communication Pre-service Certificate    \_\_\_Yes \_\_\_No  
e. 45 Hour Administrative Training Pre-service Certificate    \_\_\_Yes \_\_\_No

50. Do you have staff who have you taken any of the following:

a. Maryland Model For School Readiness (MMSR)    \_\_\_Yes \_\_\_No

b. Trainings in Core of Knowledge Categories:

Child Development    \_\_\_Yes \_\_\_No  
Curriculum    \_\_\_Yes \_\_\_No  
Health, Safety and Nutrition    \_\_\_Yes \_\_\_No  
Professionalism    \_\_\_Yes \_\_\_No  
Special Needs    \_\_\_Yes \_\_\_No

Community

Yes  No

c. SIDS Training

Yes  No

d. Medication Administration Training

Yes  No

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

---

---

---

52. 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.

---

---

53. Is there anything else you would like to share with parents about your program?

---

---

---

---

---

---

---