

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 GROUP PROGRAM QUESTIONNAIRE



Instructions: Please complete a separate questionnaire for each licensed program facility/site which you operate. Please follow all instructions carefully to insure accurate information is maintained on your facility(s) and programs. This questionnaire is for many different kinds of programs. If the question does not apply to you, please indicate with a "NR" (not relevant) in the space provided. If you have any questions, please call the LOCATE staff at your local child care resource center.

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. Site Director _____

9. 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 | |

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10. 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 _____

11. 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

12. 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

13. 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

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

Sun ____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Sat ____

15. 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

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

17. Are you open:

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

18. 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

19. 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

20. Please circle all that apply to your staff:

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): _____

21. Please check the meals that you provide:

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

22. Does your center menu accommodate special diets (ex: kosher, vegetarian, severe food allergies)?
Yes No If yes, which ones? _____

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.

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

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

25. 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 _____

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26. 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 _____

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

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 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 child care center 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 35-42 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, children's mental health, and computer usage by the child care community.

35. a. **STAFF SIZE:**

	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): _____			

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

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

44. 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: _____

Special Needs Care

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:

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

46. Please indicate the number of your staff who have completed the following levels of education:

- | | | |
|--|---|--|
| <input type="checkbox"/> Less than High School | <input type="checkbox"/> Associate Degree | <input type="checkbox"/> Master Degree |
| <input type="checkbox"/> GED/High School | <input type="checkbox"/> Bachelor Degree | <input type="checkbox"/> Doctoral Degree |

47. a. Has anyone on your staff completed college level credit courses in Early Childhood Development or Early Childhood Education? Yes No If yes, how many staff? _____

b. Does anyone on your staff have a college degree in Early Childhood 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 professional teaching certificate in Special Education issued by Maryland State Department of Education? Yes No If yes, how many staff? _____

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