MARYLAND FAMILY NETWORK

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 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

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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

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If yes, which language(s): ____

20. Please check all that apply to your home:

_______ Apartment/condo
_______ Townhouse
_______ Single family home
_______ Trailer
_______ Duplex

_______ Fenced yard
_______ Swimming pool
_______ Pets
Type of pets: ______________________________________
____

_______ 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:

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

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

Yes No If yes, which ones? ____

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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

_____ Delayed Development
_____ Down Syndrome
_____ Fragile X
_____ Learning Disabled
_____ Intellectual Disability
_____ Speech/Language Delay
_____ Traumatic Brain Injury

Physical

_____ Arthritis
_____ Cerebral Palsy
_____ Hearing/Vision Loss
_____ Low Muscle Tone
_____ Muscular Dystrophy
_____ Orthopedic
_____ Paraplegic
_____ Quadriplegic
_____ Spina Bifida

Medical

_____ Apnea Monitor
_____ BPD
_____ Blood/Organ Disorder
_____ Cancer
_____ Colostomy Bags
_____ Cystic Fibrosis
_____ Diabetes
_____ Drug Addicted/Exposed Newborns
_____ Feeding Problems/ GI Tubes
_____ Genetic Disorder
_____ George DeLange Syndrome
_____ Heart Condition
_____ HIV+/AIDS
_____ Hydrocephalus
_____ Lead Poisoning
_____ Prematurity
_____ Respiratory
_____ Severe Allergies
_____ Severe Asthma
_____ Seizure Disorder
_____ Trach Tube

Social/Emotional

_____ Adjustment Disorder
_____ Asperger Syndrome
_____ Attachment Disorder
_____ Attention Deficit Disorder
_____ Attention Deficit Hyperactivity Disorder
_____ Autism
_____ Behavior Problems
_____ Bipolar Disorder
_____ Emotional Problems
_____ Mood Disorder
_____ Obsessive-Compulsive Disorder
_____ ODD (Oppositional Defiant Disorder)
_____ PDD (Pervasive Development Disorder)
_____ Post-Traumatic Stress Disorder
_____ Sensory Integration Dysfunction
_____ Depression

c. Please circle all that apply to your program:

Currently wheelchair accessible	Yes	No
Know sign language	Yes	No

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EDUCATION

45. 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

46. 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

47. 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

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

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