



# 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. Site 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 or charter elementary schools that you may transport to/from:

b. Primary public middle school \_\_\_\_\_

Name of public, private or charter middle schools that you may transport to/from:

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. a. Do you offer care: \_\_\_\_\_ Full time? \_\_\_\_\_ Part-time? \_\_\_\_\_ Both?

b. 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. Will you administer prescribed medication with written permission?

Yes No

21. Does anyone on your staff speak more than one language fluently?

Yes No

If yes, which language(s): \_\_\_\_\_

22. 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 |

23. Are you willing to accommodate a special diet for a child?    Yes    No

24. Due to concerns of severe food allergies, is your center/program a peanut/nut-free environment?    Yes    No

**DEPOSITS, FEES AND ADDITIONAL INFORMATION:**

25. 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



The information you provide for Questions 35-40 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.

35. 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**

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. 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 \_\_\_\_\_
39. Have you ever referred a child or children for early intervention services?  
 Yes \_\_\_\_\_ If yes, how many? \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_
40. Did you terminate the care of a child due to behavior problems between January 1, 2013 and December 31, 2013?  
 Yes \_\_\_\_\_ If yes, how many? \_\_\_\_\_ No \_\_\_\_\_

41. 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"/> Learning Disability	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Low Muscle Tone
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Speech/Language Delay	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Fragile X	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Hearing/Vision Loss	<input type="checkbox"/> Orthopedic
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Other _____	<input type="checkbox"/> Limited Mobility (requires a wheelchair)	<input type="checkbox"/> Spina Bifida
			<input type="checkbox"/> Other _____
<b>Medical</b>		<b>Social/Emotional</b>	
<input type="checkbox"/> Apnea Monitor	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Emotional Problems
<input type="checkbox"/> BPD	<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Attachment Disorder	<input type="checkbox"/> Mood Disorder
<input type="checkbox"/> Blood/Organ Disorder	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> ADD(Attention Deficit Disorder)	<input type="checkbox"/> Obsessive-Compulsive Disorder
<input type="checkbox"/> Bowel Disorder	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> ADHD (Attention Deficit Hyperactivity Disorder)	<input type="checkbox"/> ODD (Oppositional Defiant Disorder)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Prematurity	<input type="checkbox"/> Autism Spectrum	<input type="checkbox"/> Post-Traumatic Stress Disorder
<input type="checkbox"/> Colostomy Bags	<input type="checkbox"/> Reflux	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Sensory Integration Dysfunction
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Social Communication Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Severe Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Other _____
<input type="checkbox"/> Drug Addicted/ Exposed Newborns	<input type="checkbox"/> Severe Asthma		
<input type="checkbox"/> Feeding Problems/ GI Tubes	<input type="checkbox"/> Seizure Disorder		
<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Sickle Cell		
<input type="checkbox"/> Other _____	<input type="checkbox"/> Trach Tube		

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**

42. 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 \_\_\_\_\_

43. Has anyone on your staff completed college level credit courses in Child Development or Early Childhood Education?  
Yes No If yes, how many staff? \_\_\_\_\_

44. 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**

45. 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

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

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47. 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.

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48. Does your center follow any of the following State-approved curricula?  
\_\_\_ *InvestiGator-Club (ages 3, 4 & 5)*  
\_\_\_ *Frog Street Preschool (age 4)*  
\_\_\_ *Little Treasures (age 4)*  
\_\_\_ *DLM Early Childhood Express (ages 3 & 4)*  
\_\_\_ *Kinder Corner and Curiosity Corner (ages 4 & 5)*  
\_\_\_ *Creative Curriculum for Preschool (ages 3 & 4) and Family Child Care (ages 3, 4 & 5)*  
\_\_\_ None of the above

49. a. If you don't follow a State-approved curriculum, do you follow any pre-school curriculum? Yes No  
b. If yes, what is the name of the curriculum that you follow?

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