

Family Child Care Questionnaire
Page 2

12. Please check the days of the week that you are regularly open:
Sun____ Mon____ Tues____ Wed____ Thurs____ Fri____ Sat____

13. 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

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

15. Are you open:
9 or 10 months (closed in summer) _____ 12 months (year-round) _____
Summer only _____ During school vacations _____

16. 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

17. 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

18. 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): _____

19. Please check all that apply to your home:

apartment/condo	_____	fenced yard	_____
townhouse	_____	swimming pool	_____
single family home	_____	pets	_____
trailer	_____	<i>(list type of pets under question #42.)</i>	
duplex	_____		
	totally smoke-free environment	_____	
or	smoke-free during child care hours	_____	
or	smoke outside during child care hours	_____	

Family Child Care Questionnaire
Page 3

20. Please check the meals that you provide:

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

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

22. 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	Y N	\$_____ per week	\$_____ per day
6+ yrs.-full time (holidays/summer)	Y N	\$_____ per week	\$_____ per day
Before/after preschool	Y N	\$_____ per week	\$_____ per day
Before/after school	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 23.

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	Y N	\$_____ per week	\$_____ per week	\$_____ per day
6+ years	Y N	\$_____ per week	\$_____ per week	\$_____ per day

Deposits, Fees and additional information:

23. Do you require a security deposit? Yes No
If yes, how much? \$_____

24. Do you require a registration fee? Yes No
If yes, how much? \$_____

25. Provide care for up to what age? _____years
26. Are you part of the Child and Adult Care Food Program? Yes No
27. Are you a member of your local Family Child Care Provider Association? Yes No
28. Does your program have an emergency preparedness plan? Yes No
29. Have you received formal emergency preparedness training for your program? Yes No

The information you provide for Questions 30-37 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.

30. 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: _____			

31. Do you currently have a child or children with special needs or disabilities enrolled in care?
Yes ____ If yes, how many? ____ No ____
32. 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 ____
33. 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 ____
34. Have you ever referred a child or children for early intervention services?
Yes ____ If yes, how many? ____ No ____ Don't know ____
35. Have you ever had to terminate the care of a child due to behavior problems?
Yes ____ If yes, how many? ____ No ____
36. Do you have a working computer? ____Yes ____ No
37. Do children have access to a computer in your child care program? ____Yes ____No

Special Needs Care

38. 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

- | | |
|--|---|
| <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Speech/Language Delay |
| <input type="checkbox"/> Fragile X | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Learning Disabled | |

Physical

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Paraplegic |
| <input type="checkbox"/> Hearing/Vision Loss | <input type="checkbox"/> Quadriplegic |
| <input type="checkbox"/> Low Muscle Tone | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Muscular Dystrophy | |

Medical

- | | |
|---|---|
| <input type="checkbox"/> Apnea Monitor | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> BPD | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Blood/organ Disorder | <input type="checkbox"/> Hydrocephalus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lead Poisoning |
| <input type="checkbox"/> Colostomy Bags | <input type="checkbox"/> Prematurity |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Allergies |
| <input type="checkbox"/> Drug Addicted/Exposed | <input type="checkbox"/> Severe Asthma |
| <input type="checkbox"/> Newborns 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 | |

Social/ Emotional

- | | |
|---|---|
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Attachment Disorder | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> ODD (Oppositional Defiant Disorder) |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> PDD (Pervasive Development Disorder) |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Post-traumatic Stress Disorder |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Sensory Integration Dysfunction |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Sensory Integration Dysfunction |
| <input type="checkbox"/> Depression | |

c. Please circle all that apply to your program:

- | | | |
|---------------------------------|-----|----|
| currently wheelchair accessible | Yes | No |
| know sign language | Yes | No |

Education

39. Check the highest level of education you have completed (*check only one*):

- | | | |
|--|---|--|
| <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 |

40. 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

41. 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

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

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.

Full-Time Enrollment

43. How many children under 2 years of age do you have currently enrolled in your program? _____
44. How many children ages 2-4 years of age do you have currently enrolled in your program? _____
45. How many 5 year olds do you have currently enrolled all day, all year in your program? _____
(These are the 5 year olds who did not make the September 1st kindergarten age cutoff.)
46. How many school age children do you have enrolled full time (summer and holiday care) in your program? _____

Before and After School Enrollment

47. If you provide before and after school care, how many children 5 years and older are currently enrolled? _____