Business Information Form for Family Child Care Programs

illinois action for children
CELEBRATING 55 YEARS

4753 N. Broadway, Ste. 1200, Chicago, IL 60640 ● Ph: 312-823-1347 ● Fx: 312-823-1200

Please fill-in your program's current information by typing in the purple form fields or by clicking in the check boxes that apply to your program.

Please review and provide information for **all** fields.

Provider ID: _____

1. **Basics About Your Child Care Program** – *Provider General: (please print)* Date Completed: _____

Business Name *(if licensed, as it appears on license)*: _____

Contact Person: _____ Title: _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____ ZIP Code _____ ZIP+4: _____ County: _____ Region: _____

Mailing Address *(if different than above)*: _____

City: _____ ZIP Code: _____

Business Phone Number: _____ Ext.: _____

Other Phone Number: _____ Ext.: _____

Fax Number *(if applicable)*: _____ E-mail Address *(if applicable)*: _____

Business Website Address *(if applicable)*: _____

Type Of Care – *Provider General:* Which is your primary purpose of your program *(check only one)?*

☐ Family Child Care Home ☐ In Home Care (for client side purposes only)

First Provided Care – Enter date the provider/program began care with current license, if licensed: _____

Source:

☐ Phone Book ☐ Organization/Agency ☐ Friend/Provider ☐ DCFS ☐ IDHS ☐ CCRR Promotional

☐ CCRR Publicity Paid ☐ CCRR Publicity Free ☐ Internet ☐ Other

Care Setting – *Provider Specifics:*

☐ House ☐ Apartment ☐ Townhouse ☐ Mobile Home ☐ Duplex ☐ Non-Residential ☐ Employer

Computer

Do you have a computer on–site? ☐ Yes ☐ No *(If No, skip the next question about Internet Service.)*

Does this on-site computer have Internet Service? ☐ Yes ☐ No

License Information – *Provider General (check only one)*:

☐ My program is License-Exempt

☐ My program is licensed/regulated by the Department of Children & Family Services (DCFS)

Regulation Status: _____ **License ID Number:** _____ **Expiration Date:** _____

License Type – *Provider General (check all that apply):*

☐ Day ☐ Overnight ☐ Family Child Care ☐ Group Home

Day-time Capacity

Total day-time license *or* exempt capacity: _____

Total desired day-time capacity *(maximum # of children you plan to care for at any one time):* _____

Total day-time vacancies you currently have: _____ as of _____ (general vacancy date)

Night-time Capacity

Night Capacity *(total overnight capacity listed on license or exempt capacity):* _____

Total desired night-time capacity *(maximum # of children you plan to care for at any one time)*: _____

Total night-time vacancies you currently have _____as of_____(general vacancy date)

Ages – Ages of children you are willing to accept *(enter the number and circle weeks/months or years)*:

Age of youngest child: _____weeks _____months _____years

Age of oldest child: _____weeks _____months _____years

Funding – *Provider General: (check all that apply)*

☐ My program receives Head Start funding.

☐ My program receives Illinois Board Of Education Pre-K funding.

☐ I am a non-profit organization.

2. **Referral Status** – *Provider General: (check all that apply)* Referral Status means you are willing to have your name given to parents looking for child care:

☐ I want to be part of the referral service (regardless of current openings)

☐ I do not wish to be part of the referral service.

☐ I am willing to take calls from parents who need care over 3 months from now *(accepts advance calls)*.

☐ I am willing to be included in the Internet services.

☐ I am temporarily not currently providing childcare due to maternity leave, extended leave, etc.

☐ Date _____ expected to be providing care.

3. **School Information** – *Provider General:*

Elementary school district you are assigned to: _____ District #: _____

Elementary school(s) your address is assigned to: _____

My program is within walking distance of the school(s) listed above: ☐ Yes ☐ No

My program provides regular transportation. ☐ Yes ☐ No If Yes, see below.

☐ May provide, on family to family basis

☐ To/From Home ☐ To/From Preschool ☐ To/From School ☐ To/From Activity

☐ To/From Other *(please explain)*: _____

☐ My program is located near public transportation (Example: bus line, train, etc.)

4. **Program Information** – *Provider General:*

☐ Montessori Teacher Training Certificate from an organization affiliated with Montessori Accreditation Council (MACTE), American Montessori Society (AMS), or Association Montessori International (AMI).

☐ I incorporate religious curriculum or practices into my program.

☐ I provide a parent co-op service singly or as part of other services.

☐ I provide respite care. *Enter in Provider Attributes (occasional care for children with disabilities)*

☐ I am willing to reserve a slot for Teen Parents in need of child care. (*Provider Attributes*)

5. **Program Environment** – *Provider Attributes: (check all that apply)*

☐ I have pets. ☐ Indoor ☐ Outdoor *(do not include fish aquariums)*

☐ I maintain a smoke-free environment *(no smoking allowed at any time)*.

☐ I have a fenced yard *(outdoor play area used for child care is completely fenced in)*.

☐ My program is wheelchair accessible.

☐ My program has an indoor/outdoor pool.

☐ My program is located on waterfront property.

6. **Safety** – *Provider Attributes:*

☐ Provider/staff has valid CPR (Cardiac Pulmonary Resuscitation) certification.

☐ Provider/staff has valid certification in First Aid Training.

☐ My program has an on-site nurse.

7. **Special Needs** – *Provider Attributes:*

Enter the number of children with Special Needs currently enrolled in your program: _____
(A child with special needs/disabilities is a child who has been diagnosed by a professional and is receiving special services from a public school, community agency, or regular care by a physician for a medical condition.)

☐ I have experience w/caring for a child w/special emotional needs and/or behaviors i.e. ADD, ADHD, etc.

☐ I have experience with caring for a child with physical needs i.e. allergies, diabetes, asthma, etc.

☐ I have experience in caring for a child with developmental delays.

☐ I can sign fluently to communicate on a daily basis.

☐ I have experience or training in caring for a child who has asthma and uses a nebulizer or inhaler or has life-threatening allergies.

☐ I have experience or training in working with a child with visual/hearing impairments.

☐ I have experience or training in working with children who have sensory disabilities (tactile deficiency, over-stimulation due to environment).

☐ I have experience or training for a condition, which requires medical procedure to be performed by the provider such as tube feedings, diabetes, monitor or seizures.

☐ I have experience or training of a child diagnosed with autism.

☐ I have experience or training in caring for a child(ren) who are gifted.

☐ I have experience or training in caring for premature infant(s).

☐ I have experience caring for a child with other types of special needs.

8. **Meals** – *Provider Attributes:*

☐ I am a member of the USDA food program. ☐ I provide breakfast. ☐ I provide AM snacks. ☐ I provide lunch.

☐ I provide PM snacks. ☐ I provide dinner. ☐ Parents are asked to furnish child's own meals/snacks.

☐ I accommodate special diet such as health, religious and/or cultural.

9. **Child Care Assistance** (Accept Subsidy) – *Provider Attributes: (check all that apply)*

☐ I will consider accepting IL Department of Human Services certificate payment, administered by the CCR&R subsidy unit, to serve children eligible for subsidized care.

☐ My program has an annual IL DHS contract to serve a specified number of children eligible for DHS subsidized care.

☐ I will consider accepting IL DCFS Vouchers for foster children, protective services, or special needs children.

☐ I offer scholarships to parents to help cover the cost of care.

☐ I charge tuition on a sliding fee scale based on family income.

☐ I am an employer-sponsored program, which offers some form of financial assistance to employees of a designated employer.

☐ I am willing to negotiate rates with families.

☐ Multi Child Discount

10. **Program Policies** – *Provider Attributes: (check all that apply)*

☐ My rates may be given out to parents. ☐ I charge when a child is absent due to illness.

☐ I charge when a child is absent due to vacation or a holiday. ☐ I give a discount for more then 1 child per family.

☐ I ask families to sign written contracts. ☐ I have written policies for families.

☐ I provide contracts, policies or other business materials in languages other then English.

Which languages? _____

☐ Full-time Assistant ☐ Part-time Assistant ☐ Exempt to License

11. **Languages** - *Provider General: (check all that apply)*

I am/staff is fluent in language marked below in order to communicate on a daily basis with child and/or parent.

☐ English ☐ Spanish ☐ Native American (Ojibwe, Lakota, etc.) Please specify: _____

☐ Asian language Please Specify: _____

☐ African language. Please specify: _____

☐ European language. Please specify: _____

☐ Other: Please Specify: _____

12. **Accreditation/Credential/Affiliations** – *Provider Attributes:*

My program is accredited by:

☐ NAFCC - National Association for Family Child Care expiration date: _____

☐ Great START ☐ CDA/CCP

☐ Other Accreditation *(specify)*: _____, expiration date: _____

☐ I am a member of a local or county early childhood association.

☐ I am a member of a state early childhood association.

☐ I am a member of a national childhood association.

☐ I am in partnership with Head Start/Family Child Care home.

☐ I am in partnership with another entity other than a Head Start/Family Child Care home. If so, please explain:

_____

☐ I am a FCC belonging to a network in which a central agency may provide ongoing training, support and/or administers public subsidy funds for some of the provider's child care spaces.

Information Requested

☐ I would like more information on the above organizations.

☐ I would like more information on becoming accredited.

13. **Training** – *Provider Attributes: (check all if you have completed them)*

☐ Foundations of Family Child Care Training ☐ Special Care Training

☐ ECE Training (non-credit) ☐ Creative Curriculum for Family Child Care

☐ Creative Curriculum for Early Childhood ☐ Creative Curriculum for Infant/Toddlers

☐ Second Helping training

☐ ECE w/college credit - I have completed some college level early childhood courses but not working on a degree.

☐ West Ed 1 & 2 ☐ West Ed 3 & 4

Information Requested

☐ I would like more information regarding training opportunities.

14. **Education** – *Provider Attributes:*
(Do not check if you are in the process of completing coursework for any items listed below – ONLY check if the education program has been completed.)

☐ High School/GED ☐ 2 yr. Degree ☐ 4 yr. Degree ☐ MA/MS or Higher ☐ Early Childcare Education Degree

☐ Health Degree ☐ Special Education ☐ ISBE Pre-K Certification ☐ Elementary Education ☐ TEACH Recipient

☐ I would like more information on the above education/degree opportunities

Professional Interests/Skills – *Provider Attributes:*

Getting involved with other child care professionals is an important way to gain and share knowledge and skills that can improve the quality of child care for all children in our community. CCR&R's offer several opportunities for involvement, including becoming a trainer or member of a committee. Please indicate yours or your staffs interest in the following opportunities (check all that apply):

☐ I am willing to be on CCR&R committees. *(Substitute stipends may be available for you to attend.)*

☐ I am interested in being a trainer for early childhood training.

☐ I am willing to be a grant reviewer.

☐ I am willing to volunteer at community events. *(example: parent fairs, conferences, etc.)*

☐ I am willing to be mentors to other child care programs.

☐ Provider gives consent to release their name for networking purposes.

15. **Hours of Operation** – *Provider Shifts:*

Number of shifts you are open: _____ *(For each shift, please fill in the table below indicating AM and/or PM.)*

A=AM P=PM

DAY			EVENING			OTHER		
Days	**Start Time**	**End Time**	**Days**	**Start Time**	**End Time**	**Days**	**Start Time**	**End Time**
Monday	_____A _____P	_____A _____P	Monday	_____A _____P	_____A _____P	Monday	_____A _____P	_____A _____P
Tuesday	_____A _____P	_____A _____P	Tuesday	_____A _____P	_____A _____P	Tuesday	_____A _____P	_____A _____P
Wednesday	_____A _____P	_____A _____P	Wednesday	_____A _____P	_____A _____P	Wednesday	_____A _____P	_____A _____P
Thursday	_____A _____P	_____A _____P	Thursday	_____A _____P	_____A _____P	Thursday	_____A _____P	_____A _____P
Friday	_____A _____P	_____A _____P	Friday	_____A _____P	_____A _____P	Friday	_____A _____P	_____A _____P
Saturday	_____A _____P	_____A _____P	Saturday	_____A _____P	_____A _____P	Saturday	_____A _____P	_____A _____P
Sunday	_____A _____P	_____A _____P	Sunday	_____A _____P	_____A _____P	Sunday	_____A _____P	_____A _____P

Additional Comments Regarding Schedules:

☐ My hours of operation are flexible to: ☐ one hour earlier then normal hours and/or ☐ 1 hour after normal closing.

16. **Schedules Accepted** – *Provider Shifts:*

I am open: *(check all that apply)* ☐ Full-time (more then 35 hours/week) ☐ Part-time (34 hours or less/week) ☐ Both

I am open: *(check only one)* ☐ Full Year ☐ School Year Only ☐ Summer Only

I accept the following schedule(s): *(check all that apply)*

☐ Drop-in *(used infrequently)*
☐ Temporary/emergency *(short-term, back-up care, space permitting)*
☐ Before School
☐ After School
☐ 24-hour
☐ Holidays *(open holidays and/or during school breaks)*
☐ Rotating *(varying schedules, example: Monday/Wednesday one week, Tuesday/Thursday next week)*

Rates – *Provider Shifts:*

If you provide childcare during weekdays (Monday-Friday) please list the **three** most common full-time and/or part-time rates you charge to parents for each age group you serve in the box below. (See example rates)

Example Types of Rates:

Weekly Full-time (WFT)
Daily Full-time (DFT)
Hourly Full-time (HFT)
Monthly Full-time (MFT)
Other Full-time (OFT)

Weekly Part-time (WPT)
Daily Part-time (DPT)
Hourly Part-time (HPT)
Monthly Part-time (MPT)
Other Part-time (OPT) *(Please explain "other" rates.)*: _____

WEEKDAY RATES

Age Group	Example Rate	Rate #1	Rate #2	Rate #3
Type of Rate	HFT			
Infant	$2.50			
Toddler (ages 15 months to 2 years)	$2.25			
2 Year Olds	$2.25			
3-4 Year Olds	$2.00			
5 Year Olds & Kindergarten	$2.00			
School-Age *Before and After Rates Only*	$2.00			
School-Age Care *Summer Care Only*	$2.00			

If you offer non-standard hour care (evenings, overnights, and weekends), please list your rate for each age group you serve. (See the example rate.)

NON-STANDARD HOUR RATES

Age Group	Example Rate	Evening	Overnight	Weekend
Type of Rate	Hourly FT			
Infant	$2.50			
Toddler (ages 15 months to 2 years)	$2.25			
2 Year Olds	$2.25			
3-4 Year Olds	$2.00			
5 Year Olds & Kindergarten	$2.00			
School-Age *Before and After Rates Only*	$2.00			
School-Age Care *Summer Care Only*	$2.00			

Other Fees – *Provider Shift One:*

I charge a registration/application fee. ☐ Yes Specify amount $_____ ☐ No

I charge a deposit. ☐ Yes Specify amount $_____ ☐ No

Capacity and Vacancies – Provider Shift One: (Please enter appropriate number of children where applicable for each shift that you are open)

DAY

Age Group	*Desired Capacity	**License Capacity	Full-time Vacancy	Part-time Vacancy	Earliest Vacancy Date	***Current Enrollment	Child/ Adult Ratio
Infant							
Toddler (ages 15 months to 2 years)							
2 Year Olds							
3-4 Year Olds							
5 Year Olds & Kindergarten							
School-Age *Before and After Only*							
School-Age Care *Summer Care Only*							

* Desired capacity is the number of children in each age group you prefer to have.
** Total capacity stated by licensure or if licensed exempt number of children allowable to be legal.
*** Full-Time Day only.

EVENING

Age Group	*Desired Capacity	**License Capacity	Full-time Vacancy	Part-time Vacancy	Earliest Vacancy Date	***Current Enrollment	Child/ Adult Ratio
Infant							
Toddler (ages 15 months to 2 years)							
2 Year Olds							
3-4 Year Olds							
5 Year Olds & Kindergarten							
School-Age *Before and After Only*							
School-Age Care *Summer Care Only*							

* Desired capacity is the number of children in each age group you prefer to have.
** Total capacity stated by licensure or if licensed exempt number of children allowable to be legal.
*** FT Day only.

OTHER

Age Group	*Desired Capacity	**License Capacity	Full-time Vacancy	Part-time Vacancy	Earliest Vacancy Date	***Current Enrollment	Child/ Adult Ratio
Infant							
Toddler (ages 15 months to 2 years)							
2 Year Olds							
3-4 Year Olds							
5 Year Olds & Kindergarten							
School-Age *Before and After Only*							
School-Age Care *Summer Care Only*							

* Desired capacity is the number of children in each age group you prefer to have.
** Total capacity stated by licensure or if licensed exempt number of children allowable to be legal.
*** FT Day only.

17. **Wages and Benefits** – *Provider Specifics:* The wage and benefits information you provide will be combined with information submitted by others who work in child care in Illinois that support the efforts to improve wages and access to benefits for the child care profession. Your confidentiality will be protected, and the information on wages and benefits will not be released in any way that identifies your name or program.

Wage *(Optional)*
Report only the provider's net annual income from Schedule C, Line 31 of federal tax return.

☐ $5,000 or less ☐ $5,000 – 11,000 ☐ $11,001 – 17,000 ☐ $17,001 – 23,000 ☐ Over $23,000

☐ Do not wish to provide

Benefits *(Optional)*

☐ No health coverage ☐ Partial medical ☐ Full medical ☐ CHIP/Kids Care ☐ Medical for dependents

☐ Medical through spouse/partner ☐ Pd Sick leave ☐ Pd Vacation leave ☐ Pd Holiday leave ☐ Retirement

18. **Ethnicity** – *Provider Specifics:* ***(Optional)***
We are committed to creating and promoting a culturally responsive child care system. The information collected below is important in helping us track the entry and participation of people of different cultures and ethnic groups in the child care field. It will also help us provide funding, training, and outreach to childcare providers of all cultural backgrounds. This information will not be provided to parents seeking childcare referrals.

Is this person Spanish/Hispanic/Latino:

☐ Mexican, Mexican American, Chicano

☐ Puerto Rican

☐ Cuban

☐ Other Spanish/Hispanic/Latino, please specify: _____

What is the person's race:

☐ White

☐ Black or African American

☐ American Indian or Alaska Native, please specify tribe: _____

☐ Asian Indian

☐ Native Hawaiian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Vietnamese

☐ Other Asian, please specify: _____

☐ Guamanian or Chamorro

☐ Samoan

☐ Other Pacific Islander, please specify: _____

☐ Other Race, please specify: _____

Does this person speak a language other than English at home: _____

Staff #1:
What Languages: _____
How well does this person speak English?
☐ Very Well ☐ Well ☐ Not Well ☐ Does not speak English

19. **Special Description** -
Use the lines below to describe additional information you would like parents to know about your program. This information maybe shared with parents as written. (Maximum of 5 lines allowed.)

My program is unique because:

_____

_____

_____

_____

_____

Your Privacy Rights and Data Release Agreement:

The purpose of collecting this information is to:

1) Provide referrals to parents who are looking for childcare. Only providers who have indicated their participation in # 2 of this survey will be included. This may be through mail, phone or other means;
2) Provide training and technical assistance to meet your program needs;
3) Report and gather statistics on child care supply and demand. This data influences planning, policy development, funding levels. Statistical information, which does not include provider names, may be shared with the Department of Human Services, Department of Children & Family Services, communities, foundations and others;
4) Provide mailing labels to approved organizations or agencies offering professional development or funding opportunities to child care providers (such as conferences, grants, Great START, TEACH, etc.) We do not provide mailing labels for solicitation purposes.
5) By completing this survey your program may be eligible for funding to expand or improve your program.

Note: You are not required to provide this information, but without it, we will not be able to fully meet the duties outlined above. This notice covers all changes you make in your file (by phone, in person, or written form) until your file is deleted from the database.

I authorize the information in this form to be used as outlined above and all information is true to the best of my knowledge.

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____

Thank you for your dedicated work for Illinois children and families!

Please <u>make a copy of this form for your records</u> and <u>return the original to</u>:
Illinois Action for Children
Attn: Provider Programs, Referral Database Team
4753 N. Broadway, Suite 1200
Chicago, IL 60640