YWCA Child Care Solutions
Annual Update Form for Child Care Centers

Basics About Your Child Care Program ***(please print)***

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

Contact Person _____ Title _____

Street Address _____

City _____ ZIP Code _____ County _____ Region _____

Mailing Address *(if different than above)* _____

City _____ ZIP Code _____

Business Phone Number (_____) _____ - _____ Ext._____ Secondary Phone Number (_____) _____ - _____

Fax Number *(if applicable)* (_____) _____ - _____

E-mail Address *(if applicable)*_____@_____

Business Web Site Address *(if applicable)* _____

Type of Care ***(check only one)*** Which is your primary purpose of your program?

☐ Child Care Center
☐ Head Start/Early Head Start Only
☐ Before/After School Only
☐ Preschool Center Only
☐ Preschool For All Only
☐ Park/Recreation Program Only
☐ School-Age Care Program Only
☐ Special Needs Care Only

Referral Status ***(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 ***including*** **web** referrals.
☐ I want to be part of the referral service but not wish to go out on *web* referrals.
☐ We do not wish to be part of the referral service.

License Information – ***(check only one)***

☐ Our program is License Exempt
☐ Our program is licensed by the Department of Children & Family Services (DCFS)
License ID Number: _____ Expiration Date: _____/_____/_____

Ages of children you are willing/licensed to accept: ***(enter the number and check one)*** _____ ☐week(s) ☐ month(s) ☐year(s)
to: _____ ☐week(s) ☐ month(s) ☐year(s)

Capacity

Shift #1- Day Shift (6am-6pm)
Total Licensed Capacity_____
Total Desired Capacity_____
Total Vacancies_____

Shift #2-Evening Shift (6pm-12am)
Total Licensed Capacity_____
Total Desired Capacity_____
Total Vacancies_____

Shift #3- Overnight Shift (12am-6am)
Total Licensed Capacity_____
Total Desired Capacity_____
Total Vacancies_____

Funding ***(check all that apply)***

☐ Our program receives Head Start funding.
☐ Our program receives Illinois Board Of Education Pre-K funding.

Total Center Staff –_____(How many staff are currently employed in your program? Please include those staff in these positions only: Administrative Director, Director/Teacher, Teacher, Assistant Teacher, School-Age Worker, and Assistant School-Age Worker who are permanent, full-time and part-time staff in the child care program. Do not include temporary, substitute or seasonal employees.)

Languages *(check all that apply)*

Mark below the fluent languages of your staff used to communicate with the children and parents.

☐ English ☐ Spanish ☐ Native American (Ojibwe, Lakota, etc.) Please specify: _____
☐ Asian language Please Specify: _____ ☐ African language (Please specify): _____
☐ European language (Please specify): _____ ☐ Other: (Please Specify): _____

Transportation

☐ Transportation is provided by the school system.
☐ My program is within walking distance of the school(s): ☐ Yes, specify please: _____ ☐ No
☐ We are located near public transportation.

We provide regular *transportation*. If yes, see below. ☐ Yes ☐ No

☐ May provide, on family to family basis ☐ To/From Home ☐ To/From Preschool
☐ To/From School ☐ To/From Activity ☐ To/From Other: Explain_____
☐ We are located near public transportation (Example: bus line, train, etc.)

Program Information

☐ We are Montessori certified.
☐ We incorporate religious curriculum or practices into our program.
☐ We have a kindergarten on-site.
☐ We have a grade school on-site.
☐ We provide a parent co-op service as part of other services.
☐ We provide respite care. (Occasional care for children with disabilities.)

Hours of Operation – *Enter in Provider Shift One:*

*****Providers may be open for operation a maximum of 18 hours per day*****

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

SHIFT #1- Day Shift (Any hours that you are open between 6am-6pm are listed here)					**SHIFT #2-Evening Shift (Any hours that you are open between 6pm-12am are listed here)**					**SHIFT #3-Overnight Shift (Any hours you are open between 12am-6am are listed here)**				
Days	**Start Time**		**End Time**		**Days**	**Start Time**		**End Time**		**Days**	**Start Time**		**End Time**	
Monday		A		A	Monday		A		A	Monday		A		A
		P		P			P		P			P		P
Tuesday		A		A	Tuesday		A		A	Tuesday		A		A
		P		P			P		P			P		P
Wednesday		A		A	Wednesday		A		A	Wednesday		A		A
		P		P			P		P			P		P
Thursday		A		A	Thursday		A		A	Thursday		A		A
		P		P			P		P			P		P
Friday		A		A	Friday		A		A	Friday		A		A
		P		P			P		P			P		P
Saturday		A		A	Saturday		A		A	Saturday		A		A
		P		P			P		P			P		P
Sunday		A		A	Sunday		A		A	Sunday		A		A
		P		P			P		P			P		P

A=AM P=PM

*** The final portion of this update involves a **MARKET RATE SURVEY**. This is a survey that is conducted every two years to survey the "price" of child care in the local market. To do this, we need to collect information regarding a provider's rates and current enrollment. The market rate survey is used to determine equitable payment rates for subsidized child care. Provider participation is* **vitally** *important to the child care provider community. Setting fair subsidy payment rates depends on obtaining current rates from a large percentage of both center and family home providers from all regions of Illinois. Individual rate information we collect is* ***not*** *shared with parents.*

Rates and Current Enrollment

Please complete the RATE and CAPACITY sections so that we can accurately represent our region's "price" of child care.

Schedules Accepted

I am open: *(check only one)*

- ☐ Both Full & Part Time
- ☐ Full Time Only *(more than 35 hours/week)*
- ☐ Part Time Only *(34 hours or less/week)*

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
- ☐ Holidays *(open holidays and/or during school breaks)*
- ☐ Rotating (*varying schedules, example: Monday/Wednesday one week, Tuesday/Thursday next week)*

☐ I do not wish to disclose rate information.
☐ No fee charged.

Age Group	**Infants (6weeks-14 months)**	**Toddlers (15 months to 2 years)**	**2 Year olds**	**3-4 Year olds**	**5 year olds & Kindergarten**	**School-Age (Before and After School)**	**School-Age (Children attend during the summer only)**
Full-Time Rate	$	$	$	$	$	$	$
Part-Time Rate	$	$	$	$	$	$	$
Type of Rate (Check One)	☐Daily ☐Weekly ☐Monthly	☐Daily ☐Weekly ☐Monthly	☐Daily ☐Weekly ☐Monthly	☐Daily ☐Weekly ☐Monthly	☐Daily ☐Weekly ☐Monthly	☐Daily ☐Weekly ☐Monthly	☐Daily ☐Weekly ☐Monthly
Capacity and Vacancies *(Please enter appropriate number of children where applicable for each shift that you are open)*							
***License Capacity**							
Full-Time Vacancies							
Part-Time Vacancies							

* Total day-time capacity stated by licensure or if license-exempt number of children allowable to be legal.

Other Fees

I charge a *(check all that apply)*

- ☐Registration/application fee
- ☐Deposit fee
- ☐Meal/snack fee
- ☐Materials/supplies fee
- ☐Field trips fee
- ☐Transportation fee
- ☐Late pick up fee
- ☐CCAP difference **(Mark only if your program's daily rate is higher than the maximum daily CCAP rate and you charge the difference.)**

Funding *(check one)*

☐ I am a non-profit organization.

☐ I am a for profit organization.

Program Environment *(check all that apply)*

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

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

☐ We have a fenced yard (Outdoor play area used for child care is completely fenced in).

☐ Our program is wheelchair accessible.

☐ Our program has an indoor/outdoor pool.

☐ Our program is located on waterfront property.

Meals

☐ We are a member of the USDA food program. ☐ We provide breakfast. ☐ We provide AM snacks.

☐ We provide lunch. ☐ We provide PM snacks. ☐ We provide dinner.

☐ Parents are asked to furnish child's own meals/snacks.

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

Child Care Assistance Program (CCAP) *(check all that apply)*

☐ We will consider accepting IL Department of Human Services certificate payment (known as Child Care Assistance Program), to serve children eligible for subsidized care.

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

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

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

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

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

☐ We give a discount for additional children in one family.

Program Policies *(check all that apply)*

☐ Our rates may be given out to parents.

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

☐ We charge when a child is absent due to illness. ☐ We charge when a child is absent due to vacation or a holiday.

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

Which languages? _____

Safety

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

☐ Provider has valid certification in First Aid Training.

☐ Provider/program has an on-site nurse.

Special Needs

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)*

- ☐ Provider/staff have experience w/caring for a child w/special emotional needs and/or behaviors i.e. ADD, ADHD, etc.
- ☐ Provider/staff have experience with caring for a child with physical needs such as Spinal Bifida, Cerebral Palsy, etc.
- ☐ Provider/staff have experience in caring for a child with developmental delays.
- ☐ Provider/staff can sign fluently to communicate on a daily basis.
- ☐ Provider/staff have experience or training in caring for a child who has asthma and uses a nebulizer or inhaler or has life threatening allergies.
- ☐ Provider/staff have experience or training in working with a child with visual/hearing impairments.
- ☐ Provider/staff have experience or training in working with children who have sensory disabilities (tactile deficiency, over-stimulation due to environment).
- ☐ Provider/staff 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.
- ☐ Provider/staff have experience or training of a child diagnosed with autism.
- ☐ Provider/staff have experience or training in caring for a child(ren) who are gifted.
- ☐ Provider/staff have experience or training in caring for premature infant(s).
- ☐ Provider/staff have experience caring for children who use an apnea monitor.
- ☐ Provider/staff have experience caring for a child with other types of special needs. Please specify: _____

Accreditation/Credential/Affiliations

Our program is accredited by:

- ☐ NAEYC National Association for the Education of Young Children
- ☐ NAA National After School Association
- ☐ NAC National Accreditation Commission
- ☐ NECPA National Early Childhood Program Accreditation
- ☐ Other Accreditation, specify _____
- ☐ IDC Director has earned his/her Illinois Directors Credential
- ☐ Head Start partnership
- ☐ Other Partnership (with another entity not Head Start or Preschool For All) Please list: _____
- ☐ Great START
- ☐ We are a member of IL AEYC.
- ☐ We are a member of NAEYC.
- ☐ We are a member of a local center directors association.

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	
Would you like to perform your vacancy updates by email?	◉ Yes	◯ No	

Care Setting

Our program is located in a: ***(check only one)***

◉ Non-Residential ◯ Faith-Based ◯ Workplace ◯ Public School Setting ◯ College Setting ◯ Hospital Setting
◯ Chain Center ◯ None of the above, *Please Explain*: _____

Our program is: ☐ Employee Sponsored ☐ Employee Restricted ☐ Center with preschool program

Please name employer _____

Wages and Benefits (Optional) ***(Please fill in the table for applicable positions. Do not include the names of staff)***
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 staff or program.

☐ I do not wish to disclose wage information.
☐ Wages determined by the school district or other program.

* For salaried employees, please calculate an hourly wage. If the employee receives an annual salary, please calculate the hourly wage by dividing the annual salary by the # of hours worked per week and the # of weeks worked per year.

Staff Title	**Lowest Hourly Wage Offered***	**Highest Hourly Wage Offered***	**Benefits (check all that are offered)**
Director	$ _____	$ _____	☐ Partial Medical Ins. ☐ Full Medical ☐ Dental Insurance ☐ Sick Pay ☐ Vacation pay ☐ Holiday pay ☐ Retirement ☐ Training /education scholarships ☐ Discounted child care ☐ Disability Ins.
Assistant Director	$ _____	$ _____	☐ Partial Medical Ins. ☐ Full Medical ☐ Dental Insurance ☐ Sick Pay ☐ Vacation pay ☐ Holiday pay ☐ Retirement ☐ Training /education scholarships ☐ Discounted child care ☐ Disability Ins.
Teacher	$ _____	$ _____	☐ Partial Medical Ins. ☐ Full Medical ☐ Dental Insurance ☐ Sick Pay ☐ Vacation pay ☐ Holiday pay ☐ Retirement ☐ Training /education scholarships ☐ Discounted child care ☐ Disability Ins.
Assistant Teacher	$ _____	$ _____	☐ Partial Medical Ins. ☐ Full Medical ☐ Dental Insurance ☐ Sick Pay ☐ Vacation pay ☐ Holiday pay ☐ Retirement ☐ Training /education scholarships ☐ Discounted child care ☐ Disability Ins.
Aide or School-age Worker	$ _____	$ _____	☐ Partial Medical Ins. ☐ Full Medical ☐ Dental Insurance ☐ Sick Pay ☐ Vacation pay ☐ Holiday pay ☐ Retirement ☐ Training /education scholarships ☐ Discounted child care ☐ Disability Ins.
Other (please specify)	$ _____	$ _____	☐ Partial Medical Ins. ☐ Full Medical ☐ Dental Insurance ☐ Sick Pay ☐ Vacation pay ☐ Holiday pay ☐ Retirement ☐ Training /education scholarships ☐ Discounted child care ☐ Disability Ins.

Ethnicity (Optional)

We are committed to creating and promoting a culturally responsive childcare 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 child care providers of all cultural backgrounds. This information will not be provided to parents seeking childcare referrals.

Number of staff who are of (below listed) ethnicity.

☐ I do not wish to answer this question.

___ African American/Black	___ American Indian	___ Asian Indian	___ Chinese
___ Filipino	___ Guamanian or Chamorro	___ Hispanic/Latino	___ Japanese
___ Native Hawaiian	___ Samoan	___ Vietnamese	___ White

___ Other Asian, please specify: _____
___ Other Pacific Islander, please specify: _____
___ Other, please specify: _____

Number of persons on staff who speak a language other than English at home: _____
Staff #1:
What Languages: _____

Staff #2:
What Languages: _____

Your Privacy Rights and Data Release Agreement:

The purpose of collecting this information is to:

1) Provide referrals to parents who are looking for child care. Only providers who have indicated their participation in the referral service portion 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, and Gateways, 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: _____

We can accept this completed form by mail, drop off, or email:

By Mail: Attention: Annual Updates
YWCA Child Care Solutions
4990 East State Street
Rockford, IL 61108

By Email: Save this PDF file and then email the completed form to
ywcachildcaresolutions@ywcanwil.org

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