Submit

YWCA Child Care Solutions

Annual Update Form for Family Child Care Programs

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

Child Care Provider Name: _____ Contact Name: _____

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

Street Address _____

City _____ ZIP Code _____ County _____

Mailing Address *(if different than above)*_____

City _____ ZIP Code _____

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

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

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

Business Web Site Address *(if applicable)*_____

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.

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

☐ I am temporarily not providing child care due to maternity leave, extended leave, etc.

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

☐ My program is License Exempt

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

License ID Number: _____ Expiration Date: _____/_____/_____

Ages of children you are **willing to accept**: ***(enter the number and check one)***

Age of youngest child: _____ ☐ weeks ☐ months ☐ years

Age of oldest child: _____ ☐ weeks ☐ months ☐ years

Shift #1- Day Shift (6am-6pm)
Total Licensed Capacity_____
Total Desired Capacity_____
Total Vacancies_____
Are the vacancies (check all that apply)
☐ Both Full & Part Time
☐ Only Full Time
☐ Only Part Time
☐ For all ages
☐ -or specify:_____

Shift #2-Evening Shift (6pm-12am)
Total Licensed Capacity_____
Total Desired Capacity_____
Total Vacancies_____
Are the vacancies (check all that apply)
☐ Both Full & Part Time
☐ Only Full Time
☐ Only Part Time
☐ For all ages
☐ -or specify:_____

Shift #3- Overnight Shift (12am-6am)
Total Licensed Capacity_____
Total Desired Capacity_____
Total Vacancies_____
Are the vacancies (check all that apply)
☐ Both Full & Part Time
☐ Only Full Time
☐ Only Part Time
☐ For all ages
☐ -or specify:_____

Languages *(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): _____

Program Information *(Check any that apply)*

☐ Transportation is provided by the school system.

☐ My program is within walking distance of the school(s): ☐ Yes, specify please: _____ ☐ No

☐ I am near public transportation.

☐ I am willing to consider transporting children.

☐ I am Montessori certified teacher.

☐ I incorporate religious curriculum or practices into our program.

☐ I provide pre-school activities for my 3 and 4 year olds (daycare homes only).

Hours of Operation

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 chart below by listing your rate information by age group. The survey is looking for your full-time rate information on your day shift only. If you are a family daycare home you will also need to list your current enrollment information for your day shift by age group. Please list only children that are attending during the day shift and over 35 hours per week.

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 prefer not to give my rates.

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	$	$	$	$	$	$	$ $165.00
Type of Rate (Check One)	☐Daily ☐Weekly	☐Daily ☐Weekly	☐Daily ☐Weekly	☐Daily ☐Weekly	☐Daily ☐Weekly	☐Daily ☐Weekly	☐Daily ☐Weekly
ENROLLMENT INFORMATION (complete one of the sections below)							
☐ I prefer not to give my current enrollment information.							
FAMILY DAY CARE HOMES ONLY: Please list your current full-time enrollment during the day for each age group.							

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 (C***heck all that apply)***

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

☐ I maintain a smoke-free environment (no smoking & no second hand smoke 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.

Meals (*Check all that apply)*

☐ 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.

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

☐ I will consider accepting IL Department of Human Services certificate payment (known as the Child Care Assistance Program), 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

Program Policies (C***heck all that apply)***

☐ My rates may be given out to parents.

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

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

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

W*hich languages?*_____

I have: ☐ A Full-time Assistant ☐ A Part-time Assistant ☐ No Assistant

Special Needs (Check all that apply)

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 with caring for a child with special emotional needs and/or behaviors (i.e. ADD, ADHD, etc.).

☐ I have experience with caring for a child with physical needs such as (Spinal Bifida, Cerebral Palsy, 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 in caring for children who use an apnea monitor.

☐ I have experience caring for a child with other types of special needs. Please specify: _____

Education (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 Child Care Education Degree ☐ Health Degree
☐ Special Education ☐ ISBE EC Certification ☐ Elementary Education
☐ Gateways Scholarship

Accreditation/Affiliations (Check all that apply)
My program is accredited by:

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

☐ Great START ☐ Current CDA/CCP

☐ Other Accreditation, please list _____ Expiration date: _____

☐ I am a member of a local or county early childhood association. Please list: _____

☐ I am a member of a state early childhood association. Please list: _____

☐ I am a member of a national childhood association. Please list: _____

☐ 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.

Computer

Do you have a computer onsite? ■ *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

Ethnicity (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 child care providers of all cultural backgrounds. This information will not be provided to parents seeking child care referrals.

☐ I do not wish to answer this question.

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

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

Wages and Benefits 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.
☐ Do not wish to provide
☐ $5,000 or less ☐ $5,000 – 11,000 ☐ $11,001 – 17,000 ☐ $17,001 – 23,000 ☐ Over $23,000

Benefits *(Optional)*
☐ Do not wish to provide
☐ 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

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, Great START, 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: *ywcachildcaresolutions@ywcanwil.org*

Submit

Funding provided in whole or in part by the Illinois Department of Human Services