Best Beginnings Child Care Referral Program
Provider Information Form

This form is available for completion and submission online at www.familyconnectionsmt.org

First Name: _____ Last Name: _____

Business / Facility Name: _____

Would you prefer correspondence through email versus hard copy mail? (Circle one) **YES** or **NO**

If yes, please include your current email address:_____

(Initial)_____I understand that by opting to participate, I will no longer be receiving my referral correspondence by mail and that should my email address change, I need to notify the Best Beginnings Referral Program immediately.*

Type of care: (check only one)			What date did you open your child care facility?				
			Would you like to be included in the referral data base?			Y	N
	Child Care Center		**Would you like to be included in the online referral data base?**			Y	N
	Family Child Care		**This information may appear on the referral profile of your facility:**				
	School Age Program		First Name	Business Name	Address	City/state/zip	
	Group Home Child Care		Facility Type	Phone #	Hours/Days	Ages served	
	Tribal-Licensed Program		Map to street	Rates	Full/Part time		

Street Address: _____ City: _____Zip code: _____

Mailing address: _____ City: _____Zip code: _____

Primary Phone: _____ Secondary phone: _____ Fax: _____

Web site: _____

License/Provider number: **PV**_____ License Expiration date: _____

Capacity and Age Range

Total Licensed Capacity: _____ Total Desired Capacity: _____

Total number of vacancies: _____ Vacancy date: _____

Ages of children served: **FROM**: ____years ____months _____ weeks
TO: ____years ____months _____ weeks

Service Information

Please list elementary schools served_____
Are you a Head Start / Early Head Start Facility or Partner? **Yes** **No**
Do you receive Head Start funding? **Yes** **No**
Do you receive State Pre-K funding? **Yes** **No**
Do you donate operation child care hours? **Yes** **No**

Transportation Offered: ___Transportation provided ___None ___Provides family transportation ___Close to public transportation
___To/From school ___Kindergarten transportation ___Child to/from home ___To/From activities ___To/From bus stop
___On a school bus route ___Walking distance to school

What languages do you use? ____ English ____Native American ____ Spanish ____ French ___German ____ Hmong
____Russian ____ Sign Language ____ Other

Do you maintain a waiting list when you do not have vacancies? **Yes** **No**

Shifts

What are your facility's hours of operation? Please know for scholarship families, payment cannot be made for hours/days not approved by QAD

	Day Shift Traditional Hours	Start Time EX: 7:00 AM	End Time EX: 6:00 PM		**Session 1 shift Extended hours**	Start Time Before 7:00 AM	End Time After 6:00 PM
☐	Monday			☐	Monday		
☐	Tuesday			☐	Tuesday		
☐	Wed.			☐	Wed.		
☐	Thursday			☐	Thursday		
☐	Friday			☐	Friday		
☐	Saturday			☐	Saturday		
☐	Sunday			☐	Sunday		

Do you accept (check only one): ____Full-time children ____Part-time children ____Both full and part-time children

Is your facility open (check only one): ____Full year ____School year only ____Summer only

Other care accepted (check ALL that apply) ____Drop-in ____Temp/emergency ____Before/After School ____Rotating shifts ____24-hour

Are you open on some Federal holidays? ___Yes ___No

Please list the Holidays your facility is open:_____

Rates

IMPORTANT: ONLY DAILY AND HOURLY RATES WILL BE USED FOR SCHOLARSHIP PURPOSES. PLEASE COMPLETE THE PROVIDER RATE FORM IN ORDER TO REPORT YOUR CURRENT RATES.

Extra fee information (check all that apply):

☐ Transportation Fee	☐ Charges above state rate	☐ Activity fee/Registration fee
☐ Meal Fee	☐ Multi-child discount	☐ Advanced payment required
☐ Minimum daily charge	☐ Uses weekly flat rate	☐ Monthly flat rate only

Population Information

Please tell us about your current vacancies:

	Desired Capacity	Licensed Capacity	Full-time Vacancy	Part-time Vacancy	Currently Enrolled
Infant (0-23months)					
Toddler (2years)					
Preschool (3-5years)					
School Age (5+years)					

Attributes

Please tell us more about your facility, please check all that apply for each category:

What kind of environment do you offer?
___Will toilet train ___Offers field trips ___Wheelchair accessible ___No pets at facility ___No TV
___Has outdoor activities ___Structured curriculum ___Summer program ___Outdoor play equipment
___Non- smoking facility (Even when closed) ___Preschool Program ___Does not use vehicle transportation

Meals:
___Breakfast ___Morning snack ___Lunch ___Afternoon snack ___Dinner ___Evening snack
___Accommodates special meal request ___Child Care Food Program ___OPI Afterschool Snack Program

Philosophy:
___Faith based ___Montessori ___Waldorf ___Reggio Emilia ___Parent cooperative *(facility is run by parent board)* ___Other

Do you accept scholarship families? ___Yes ___No
(Please verify which scholarships you accept) ___ Best Beginnings Scholarship ___ Tribal BG ___ Respite

Policies:
___Separate sick area for children while waiting for parent to pick up
___Charges for absent days
___Closed for vacations and sick days (closes facility when on vacation or sick)
___Uses substitutes when absent (keeps facility open by using substitutes)
___Charges for holidays when facility is closed

Special Skills:
___Music ___Drama ___Art ___Sports ___Other

Safety:
___CPR Current within 2 Years ___First Aid Training ___Liability Insurance ___Health-Related Degree ___On-Site Nurse

Special Needs Experience: (Have the experience to care for children with these needs)
___ADHD/ADD ___Autism ___Catheter ___Downs syndrome ___Diabetes ___Hearing impaired
___Vision impaired ___Seizures ___Cerebral Palsy ___Tube feeding ___Asthma ___Developmentally delayed
___Fetal alcohol effect/syndrome ___Emotional/mental health ___MD Medical disability ___Food Allergies ___ Cystic Fibrosis

Annual Training (based on your registration cycle):
___8-15 hours ___16-38 hours ___39-67 hours ___68+ hours
___After-school specialized ___Pre-school specialized ___SOS or BEST graduate ___Infant-Toddler specialized

Professional Child Care Experience:
___Under 1 year ___1-3 years ___4-9 years ___10-20 years ___21+ years

Education:
___High school education ___AA, other ___Some college, child related ___Some college, other ___CDA
___Bachelors, child related ___Bachelors, other ___Masters, child related ___Masters, other ___AA, child related

Affiliation (are you a current member of the following professional organizations?)
____MTAEYC ____MTCCA

Quality Indicators:
___Extended license ___Level 1 on career path ___Level 2 on career path ___Level 3 on career path ___Level 4 on career path
___Level 5 on career path ___Level 6+ on career path

Grants Recipient:

☐ Mini grant _____ ☐ Merit pay _____ ☐ Provider grant _____
(year) *(year)* *(year)*

Other Services:
___Diaper Service ___Art Lessons ___Gymnastic Lessons ___Music Lessons ___Swimming Lessons ___Backup Care Network

Facility Setting:
___Non-residential house ___Workplace based ___ Mobile home ___Public/Private School ___ Located in church
___Intergenerational ___ Franchise ___Duplex ___Apartment ___Residential house

How did you hear about us:
___Brochure/Poster/Rack Card ___Local Child Care Resource & Referral Agency ___ Friend/Relative ___Child Care Provider ___ Community Agency
___IMedia:Newspaper/Radio/TV ___ Internet ___Quality Assurance Division ___MTCCA ___Other (Please list)_____

Provider Statement: In your own words what do you want parents to know about your facility?

FYI - This will be entered into the database and printed on the referral listing exactly as it is written.

_____

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_____

I hereby affirm that the statements in the Provider Information Form are accurate, complete and true to the best of my knowledge. I hereby authorize District 7 HRDC to share the information I have provided with parents seeking child care and for statistical purposes.

I agree to provide additional documentation concerning the Provider Information Form to District 7 HRDC at their request. I understand that District 7 HRDC reserves the right to remove my name and/or facility from the referral database. I understand that it is my responsibility to keep my provider information updated with District 7 HRDC and to complete this form on an annual basis unless otherwise requested.

_____ _____
Provider signature *Date*