



Agency Survey Addendum: Child Care

Agency Name: _____

Please complete this form to give us a clear and complete picture of the services you provide and populations you serve. Read through all of the categories and indicate all that apply to your organization on a regular basis. This completed form will help us to make only the most appropriate referrals to your organization.

Are you a licensed child care provider? Yes No
If yes, please provide a copy of your DHR license/certification.

Location of services — physical address:

- Child care center—outside of home
- Family child care home—home-based
- Out of client’s home

Programs Offered

Day Care

Do you provide structured enrichment activities during school hours?

List ages that you serve:

Hours of operation: Days: MON TUE WED THU FRI SAT SUN

Do you offer transportation to/from home to school? Yes No

Is there an added fee for this service? Yes No || If yes, specify:

Area available for pick up/drop off service:

Day care fees:

- No fee Sliding fee scale (based on client’s income)
- Straight fee—Specify:

Do you accept CAPS subsidy? Yes No

Do you offer discounts for families with multiple children in your care? Yes No

Summer Camps / Winter Camps / Spring Breaks / Fall Breaks

Do you offer programs for school-aged children during school vacation times? Yes No

Indicate which ones you offer:

What ages do you serve with these school vacation time programs?

Hours of Operation: MON TUE WED THU FRI SAT SUN

Do you offer transportation to/from home to school? Yes No

Is there an added fee for this service? Yes No || If yes, specify:

Area available for pick up/drop off service:

Name of Agency: _____

Please list specific fees:

No fee Sliding fee scale (based on client's income)

Straight fee—Specify:

After School Program (extended care)

Do you offer after school care? Yes No

Do you provide structured enrichment activities during school hours (i.e. day care)? Yes No

What ages do you serve:

Hours of operation: Days: MON TUE WED THU FRI SAT SUN

Do you offer transportation to/from home to school? Yes No

Is there an added fee for this service? Yes No || If yes, specify:

Area available for pick up/drop off service:

Please list specific fees:

No fee Sliding fee scale (based on client's income)

Straight fee—Specify:

Do you serve children who:

- | | |
|--|--|
| <input type="checkbox"/> Are not yet potty trained | <input type="checkbox"/> Have mobility challenges (i.e., wheelchair, walker) |
| <input type="checkbox"/> Have developmental disabilities | <input type="checkbox"/> Have mental/emotional disabilities |
| <input type="checkbox"/> Have a hearing impairment | <input type="checkbox"/> Have a visual impairment |

Do you administer prescribed medications? Yes No

If yes, please indicate who administers the medication:

- Nurse Practitioner
 MD
 Other staff—specify:

Meal provided:

- Breakfast
 Lunch
 Dinner
 Snack

Do you have a dietician on staff? Yes No

Who prepares the meals?

Activities Provided

Please indicate and list some activities you provide:

- | | |
|---|---|
| <input type="checkbox"/> Outdoor trips | <input type="checkbox"/> Music/dance time |
| <input type="checkbox"/> Outdoor activities | <input type="checkbox"/> Class work |
| <input type="checkbox"/> Learning games | <input type="checkbox"/> Others—specify: |
| <input type="checkbox"/> Movie Time | |
| <input type="checkbox"/> Computer access | |

List any additional information you would like to include: