

STARTING POINT

Child Care Resource and Referral Child Care Center Update Form

Center Name: _____

Site Address: _____

City: _____ **Zip:** _____ **County:** _____

Mailing Address: _____

City: _____ **Zip:** _____ **County:** _____

Contact Person: _____

Primary Phone: () _____ **ext.** _____ **Secondary Phone:** () _____ **ext.** _____

Fax #: () _____ **E-Mail Address:** _____

Website: _____

Update Method: Phone Fax Postal Mail E-Mail

Accepted Age Range:

	From:		Years		Month		Weeks
	To:		Years		Month		Weeks

Transportation:

<input type="checkbox"/> To/From Home	<input type="checkbox"/> To/From School
<input type="checkbox"/> Walking Distance to School	<input type="checkbox"/> Near Public Transportation

Which Age Groups Do You Transport?

<input type="checkbox"/> Infants (Newborns-18mos)	<input type="checkbox"/> Toddlers (18mos-36mos)
<input type="checkbox"/> Preschoolers(3yrs-5yrs not in Kindergarten)	<input type="checkbox"/> School-Agers (5yrs in Kindergarten-14yrs)

Languages:

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Asian	<input type="checkbox"/> American Sign Language
<input type="checkbox"/> Hebrew	<input type="checkbox"/> Russian	<input type="checkbox"/> Arabic	<input type="checkbox"/> Other: _____

Programs:

<input type="checkbox"/> Preschool	<input type="checkbox"/> School Year SACC	<input type="checkbox"/> Special Needs
<input type="checkbox"/> Head Start	<input type="checkbox"/> Summer SACC	<input type="checkbox"/> Sick Child Care
<input type="checkbox"/> Kindergarten	<input type="checkbox"/> 1/2 Day Kindergarten SACC	

Physical Location of Program:

<input type="checkbox"/> Non-residential Building	<input type="checkbox"/> School Building	<input type="checkbox"/> Faith-based Building
<input type="checkbox"/> College/University	<input type="checkbox"/> Workplace-based	

(Required Field**)Step-Up to Quality Star Ratings:** 1 Star 2 Stars 3 Stars 4 Stars 5 Stars

Affiliation: For Profit Non Profit College/University
 Public School School Employer Religious

Days	Start Time	End Time	Accepts Children
<input type="checkbox"/> Monday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Both
<input type="checkbox"/> Tuesday	<input type="text"/>	<input type="text"/>	Year Schedule
<input type="checkbox"/> Wednesday	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Thursday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Before School <input type="checkbox"/> Rotating <input type="checkbox"/> 24-Hour
<input type="checkbox"/> Friday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> After School <input type="checkbox"/> Temp/Emergency Care
<input type="checkbox"/> Saturday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Drop In <input type="checkbox"/> Open Holidays
<input type="checkbox"/> Sunday	<input type="text"/>	<input type="text"/>	

****Rates: (**Required Fields, Please Fill Out Completely)**

Age Groups	Weekly Full-Time	Daily Full-Time	Hourly	Monthly	Other
Infant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Toddler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preschool	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Special Rates:	Before School	After School	Before and After Full-Time	Summer/Break
School Age	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional Fees: Registration/Application Fee Deposit Transportation Fee
 Meal/Snack Fee Supply Fee

Comments: _____

Financial Assistance: Publicly Funded Child Care Sliding Fee Scale
 Multi-child Discount Scholarship

****Capacity By Age Groups: (**Required Fields, Please Fill Out Completely)**

1st Shift	Number Enrolled	Vacancies	Child/ Adult Ratio	Group Size
Infant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Toddler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preschool	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School Age	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2nd Shift	Number Enrolled	Vacancies	Child/ Adult Ratio	Group Size
Infant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Toddler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preschool	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School Age	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3rd Shift	Number Enrolled	Vacancies	Child/ Adult Ratio	Group Size
Infant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Toddler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preschool	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School Age	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(Required Fields, Please Fill Out Completely)**

Special Needs: Number of children with special needs you are willing to serve?
 Number of children with special needs currently being served?

Please list the specific special needs of children. For each of the following, list how many children have a specific need. (I.e. Asthma 3, Autism 4, etc.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Emotional/Behavioral |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hearing/Speech | <input type="checkbox"/> MR/DD |
| <input type="checkbox"/> Physical Mobility | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Other (List in comments, please be specific): | | |

Comments: _____

Environment: Field Trips Fenced Yard Pool/Waterfront Large Muscle Room
 No Pets Outdoor Pets Only Smoke Free Wheelchair Accessible

Meals: Breakfast Morning Snack Lunch Afternoon Snack
 Dinner USDA Food Program Special Diet Parent Provided

Philosophy: Developmentally Appropriate Practices Montessori
 Faith-based Curriculum Mixed Age (children)
 Parent Co-op

Accreditation: NAEYC NACCP ACSI
 NECPA COA CDA

Education: High School Education Bachelors Degree (Other)
 Workshops/Trainings Master's Degree (Child Related)
 Associates Degree (Child Related) Master's Degree (Other)
 Associates Degree (Other) Other: _____
 Bachelors Degree (Child Related) _____

Census Bureau Demographics:
Number of persons on staff who are Spanish/Hispanic/Latino:
 Mexican, Mexican Am., Chicano Puerto Rican Cuban
 Other Spanish/Hispanic/Latino (print group) _____
Number of persons on staff who's race is:
 White Black
 American Indian or Alaska Native (print tribe) _____
 Asian Indian Native Hawaiian Chinese
 Filipino Japanese Vietnamese
 Other Asian (print race) _____
 Guamanian or Chamorro Samoan
 Other Pacific Islander (print race) _____
 Other Race (print race) _____
English Ability: Number of persons on staff who speak a language other than English at home
What languages _____
How well do the persons speak English:
 Very Well Well Not Well Not At All

Update Completed by: _____
Date Completed: _____ **Best time to reach:** _____ **am/pm**

Please mail or fax the completed form to **Starting Point, 4600 Euclid Avenue, Suite 500, Cleveland, OH 44103 216-575-0102 (Fax)**. This form is also available online at www.starting-point.org. If you prefer to speak with someone directly, contact us at **216-575-0061 or 1-800-880-0971**. Thank you!

For Office Use Only

Staff Name: _____ **Program ID No.** _____
Date Received: _____ **Date Entered:** _____