

**STARTING POINT
Child Care Resource and Referral
Update Form - Preschool Programs**

Revised on 8/19/2014

Program Name: _____

Site Address: _____ **Mailing Address:** _____

Phone: _____ **Phone:** _____

(Parent Inquiries) **(Starting Point - Update)**

Contact Person: _____

Fax #: _____

Email Address: _____ **Website:** _____

Update Method: Phone Fax Postal Mail E-Mail

Ages Served: From Age: _____ years _____ month To Age: _____ years _____ month

Program Operation: Full Year School Calendar **(**Required Fields, Please Fill Out Completely)**

| <i>Days</i> | <i>Morning Program</i> | | <i>Days</i> | <i>Afternoon Program</i> | | <i>Days</i> | <i>Extended Day Program</i> | |
|-----------------------------|------------------------|-----------|-----------------------------|--------------------------|-----------|-----------------------------|-----------------------------|-----------|
| <input type="checkbox"/> M | Start _____ | End _____ | <input type="checkbox"/> M | Start _____ | End _____ | <input type="checkbox"/> M | Start _____ | End _____ |
| <input type="checkbox"/> T | Start _____ | End _____ | <input type="checkbox"/> T | Start _____ | End _____ | <input type="checkbox"/> T | Start _____ | End _____ |
| <input type="checkbox"/> W | Start _____ | End _____ | <input type="checkbox"/> W | Start _____ | End _____ | <input type="checkbox"/> W | Start _____ | End _____ |
| <input type="checkbox"/> Th | Start _____ | End _____ | <input type="checkbox"/> Th | Start _____ | End _____ | <input type="checkbox"/> Th | Start _____ | End _____ |
| <input type="checkbox"/> F | Start _____ | End _____ | <input type="checkbox"/> F | Start _____ | End _____ | <input type="checkbox"/> F | Start _____ | End _____ |

| Safety: (check ALL that apply) | Accreditation: (Check ALL that apply) | Quality Rating: |
|--|--|---------------------------------|
| CPR within 2 Years <input type="checkbox"/> | NAEYC <input type="checkbox"/> | 1 Star <input type="checkbox"/> |
| 1st Aid Training <input type="checkbox"/> | NECPA <input type="checkbox"/> | 2 Star <input type="checkbox"/> |
| On-Site Nurse <input type="checkbox"/> | NACCP <input type="checkbox"/> | 3 Star <input type="checkbox"/> |
| Liability Insurance <input type="checkbox"/> | COA <input type="checkbox"/> | 4 Star <input type="checkbox"/> |
| Health-Related Topics <input type="checkbox"/> | ACSI <input type="checkbox"/> | 5 Star <input type="checkbox"/> |

Capacity & Vacancy Information (Required Fields, Please Fill Out Completely)**

| Licensed Capacity at any one time | Morning Program | | Afternoon Program | | Extended Day Program | |
|--|------------------------|-------------------|--------------------------|-------------------|-----------------------------|-------------------|
| | Current Enrollment | Current Vacancies | Current Enrollment | Current Vacancies | Current Enrollment | Current Vacancies |
| | | | | | | |

Please Check ALL that apply: (Required Fields, Please Fill Out Completely)**

Special Needs Willing to serve children with special needs? If yes, how many:

Information: Are you currently serving children with special needs? If yes, how many?

List specific special needs of children:

Meals: USDA Food Program Breakfast Morning Snack
Check ALL that apply: Lunch Afternoon Snack
 Special Diet Parent Provided

Financial Assistance: Publically Funded Childcare Head Start
Check ALL that apply: Sliding Fee Scale Scholarship
 Multi-child Discount

Affiliation: School College/University Faith-based Institution
 Other: _____

Program Rates (Required Fields, Please Fill Out Completely) Census Bureau Questions**

| Age Group/Range | Monthly | Annually | Other | No. of persons on Staff that are Spanish/Hispanic/Latino: | | |
|-----------------|---------|----------|-------|---|--|--------------------------|
| | | | | <input type="checkbox"/> | Mexican, Mexican American, Chicano | |
| | | | | <input type="checkbox"/> | Puerto Rican | |
| | | | | <input type="checkbox"/> | Other Spanish/Hispanic/Latino print grp. _____ | |
| | | | | No. of persons on Staff who's race is: | | |
| | | | | <input type="checkbox"/> | White | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Black | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Am.Indian/Alaska Native | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Asian Indian | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Native Hawaiian | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Filipino | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Japanese | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Other Asain | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Guamanian/Chamorro | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Samoan | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Other Pacific Islander | <input type="checkbox"/> |

Staff Education: High School Education Bachelors Degree (Child Related)
Check ALL that apply: Workshops/Training Bachelors Degree (Other)
 Associates Degree (Child Related) Masters Degree (Child Related)
 Associates Degree (Other) Masters Degree (Other)

Update completed by: _____ **Phone #:** _____
Date completed: _____ **Best time to reach:** _____

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#:** _____
Date Received: _____ **Date Entered:** _____