STARTING POINT
Child Care Resource and Referral
Family Child Care Home Update Form

Provider: ____
(First Name) (Last Name)

Address: ____

City: ____________________ **Zip:** __________ **County:** ____________

Mailing Address: ____

City: ____________________ **Zip:** __________ **County:** ____________

Primary Phone: ( ) __________ **ext.** ______ **Secondary Phone:** ( ) __________ **ext.** ______

Fax #: ( ) __________ **E-Mail Address:** ____________________

Website: ____

Update Method: ☐ **Phone** ☐ **Fax** ☐ **Postal Mail** ☐ **E-Mail**

Accepted Age Range:

From:	☐	**Years**	☐	**Months**	☐	**Weeks**
To:	☐	**Years**	☐	**Months**	☐	**Weeks**

Days	**Start Time**	**End Time**
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		
☐ Saturday		
☐ Sunday		

Accepts Children

☐ Full-Time ☐ Part-Time ☐ Both

Year Schedule

☐ Full Year ☐ School Year ☐ Summer Only

☐ Drop In ☐ Temp/Emergency Care
☐ Before School ☐ After School
☐ Rotating Schedule ☐ 24-Hour ☐ Open Holidays

Scheduling Comments:

Rates:

	Weekly Full-time	**Daily Full-time**	**Daily Hourly**	**Other**
Infant				
Toddler				
Preschool				
School Age				

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

Comments:

Capacity By Age Groups:

1st Shift	Vacancies	Number Enrolled	2nd Shift	Vacancies	Number Enrolled	3rd Shift	Vacancies	Number Enrolled
Infant	☐	☐	Infant	☐	☐	Infant	☐	☐
Toddler	☐	☐	Toddler	☐	☐	Toddler	☐	☐
Preschool	☐	☐	Preschool	☐	☐	Preschool	☐	☐
School Age	☐	☐	School Age	☐	☐	School Age	☐	☐

Languages: ☐ English ☐ Spanish ☐ Asian ☐ American Sign Language
☐ Hebrew ☐ Russian ☐ Arabic ☐ Other______________________________

Safety: ☐ CPR Current Within 2 Yrs. ☐ First Aid Training ☐ Health-Related Degree
☐ On-Site Nurse ☐ Liability Insurance

Transportation: ☐ Transportation Provided ☐ To/From Home ☐ To/From School
☐ Walking Distance to School ☐ Near Public Transportation

Comments:

Policies: ☐ Child Must Be Toilet Trained ☐ Written Contract ☐ Interview Required
☐ Written Polices ☐ Has Back-up Provider ☐ Provide Sick Child Care

Family Child Care Setting: ☐ House ☐ Townhouse ☐ Duplex
☐ Apartment ☐ Mobile Home

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.)

☐ Asthma ☐ Autism ☐ Cerebral Palsy
☐ Communications ☐ Downs Syndrome ☐ Emotional/Behavioral
☐ Epilepsy/Seizures ☐ Hearing/Speech ☐ MR/DD
☐ Physical Mobility ☐ Spina Bifida ☐ Vision Impaired
☐ Other (List in comments, please be specific):

Comments:

Special Needs Training/Experience: ☐ Emotional/Behavioral ☐ Hearing/Speech ☐ Physical Mobility
☐ Medical Conditions ☐ MR/DD ☐ Visual
☐ Allergies/Asthma ☐ Other (List in comments, please be specific):

Provider has had:

Environment:
- ☐ Field Trips ☐ Fenced Yard ☐ Pool/Waterfront ☐ Large Muscle Room
- ☐ No Pets ☐ Outdoor Pets Only ☐ Smoke Free ☐ Wheelchair Accessible
- ☐ Non-Smoking During Care Hours

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

Financial Assistance:
- ☐ Public Funds through County DJFS ☐ Sliding Scale ☐ Scholarship
- ☐ Multi-child Discount ☐ United Way ☐ Employer

Accreditation:
- ☐ College Degreed ☐ College Courses ☐ CDA ☐ Workshop/Training
- ☐ Other

Affiliation:
- ☐ For Profit ☐ Non Profit ☐ College/University ☐ County Contract ☐ Employer
- ☐ Public School ☐ School ☐ Parks/Rec ☐ FCC Association/Network ☐ Religious

Census Bureau Demographics:

Is this person Spanish/Hispanic/Latino?
- ☐ No, Not Spanish/Hispanic/Latino ☐ Yes, Puerto Rican ☐ Yes, Other (print)________________________
- ☐ Yes, Mexican, Mexican Am., Chicano ☐ Yes, Cuban

What is this person's race?
- ☐ White ☐ Black/African Am./Negro ☐ 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)________________________

What is this person's ancestry or ethnic origin? ____________________________(i.e. Italian, Jamaican, African Am, Cambodian, Haitian, Korean)

Does this person speak a language other than English at home? ☐ Yes ☐ No What language? ____________________

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 This Form To:

Starting Point
2000 East 9th Street, Suite 1500
Cleveland, Ohio 44115
Phone (216) 575-0061 Fax (216) 575-0102

For Office Use Only

Staff Name: ________________________________ ***Program ID No.*** ________________

Date Received: ____________________ ***Date Entered:*** ____________________