



State of Montana
Department of Public Health and Human Services
Human and Community Services Division
Early Childhood Services Bureau
<http://www.bestbeginnings.mt.gov>



Best BEGINNINGS CHILD CARE REFERRAL PROGRAM
PROVIDER INFORMATION FORM

This form is available at each regional Child Care Resource and Referral (CCR&R) agency website. By providing information in this form, the child care facility will be added to the child care referral services for families in Montana.

FIRST NAME		LAST NAME	
BUSINESS/FACILITY NAME		LICENSE/PROVIDER NUMBER (PV#)	
ADDRESS (physical)			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS (if different)			
CITY	STATE	ZIP	COUNTY
PRIMARY PHONE NUMBER		WEBSITE	
EMAIL ADDRESS		FAX PHONE NUMBER	

Please indicate which type of child care your facility is. Select only one.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Child Care Center | <input type="checkbox"/> Family Child Care | <input type="checkbox"/> Group Child Care | <input type="checkbox"/> Tribal-Licensed Program |
| <input type="checkbox"/> School Age Program | <input type="checkbox"/> Preschool Program | <input type="checkbox"/> Head Start | |

CHILD AGES SERVED

Youngest Age Served:	Oldest Age Served:
___ Years ___ Months ___ Weeks	___ Years ___ Months ___ Weeks

CAPACITY AND VACANCIES

Infant (0-23 months)

DESIRED CAPACITY:		CURRENT ENROLLMENT:	
FULL-TIME VACANCY:	DATE VACANCY BEGINS:	PART-TIME VACANCY:	DATE VACANCY BEGINS

Toddler (2 years old)

DESIRED CAPACITY:		CURRENT ENROLLMENT:	
FULL-TIME VACANCY:	DATE VACANCY BEGINS:	PART-TIME VACANCY:	DATE VACANCY BEGINS

Preschool (3-5 years old)

DESIRED CAPACITY:		CURRENT ENROLLMENT:	
FULL-TIME VACANCY:	DATE VACANCY BEGINS:	PART-TIME VACANCY:	DATE VACANCY BEGINS

CAPACITY AND VACANCIES

School Age (6 years old and older)

DESIRED CAPACITY:		CURRENT ENROLLMENT:	
FULL-TIME VACANCY:	DATE VACANCY BEGINS:	PART-TIME VACANCY:	DATE VACANCY BEGINS:

Waiting List

Do you maintain a waiting list when you do not have vacancies? <input type="checkbox"/> Yes <input type="checkbox"/> No

Child Care Services Information

Please list public schools served:

Transportation – Choose all that apply.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation provided for children to/from the family's home.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation provided for children to and from activities.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Child care facility is located near public transportation.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation provided for children to and from school.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation provided for children to and from bus stop.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Child care facility is located within walking distance to school.

Languages

Do you speak any of the following languages? Multiple choices can be made.			
<input type="checkbox"/> English	<input type="checkbox"/> Native American	<input type="checkbox"/> Spanish	<input type="checkbox"/> French
<input type="checkbox"/> German	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Other	

Hours of Operation

Please list your facility's hours of operation:
Do you offer extended hours?
Please list the Holidays your facility is open:
Is your facility open (check only one):
<input type="checkbox"/> Full year <input type="checkbox"/> School year only <input type="checkbox"/> Summer only

Full-time and Part-time Attendance

Do you accept (check only one):		
<input type="checkbox"/> Full-time children	<input type="checkbox"/> Part-time children	<input type="checkbox"/> Both full-time and part-time children

Type of Child Care

Please check all that apply for type of care provided:			
<input type="checkbox"/> Drop-in	<input type="checkbox"/> Temporary/Emergency	<input type="checkbox"/> Before School	<input type="checkbox"/> After School
<input type="checkbox"/> Rotating Shifts	<input type="checkbox"/> 24-hour care		

Rates

Do you charge for any of the following:		
<input type="checkbox"/> Transportation Fee	<input type="checkbox"/> Charge above the state rate	<input type="checkbox"/> Registration Fee
<input type="checkbox"/> Activity Fee	<input type="checkbox"/> Meal Fee	<input type="checkbox"/> Advanced payment required
<input type="checkbox"/> Minimum Daily Charge		
Do you offer any of the following discounts:		
<input type="checkbox"/> Multi-child discount		

Attributes (Environment)

What kind of environment do you offer at your facility? Check all that apply.

<input type="checkbox"/> Will toilet train	<input type="checkbox"/> Offer field trips	<input type="checkbox"/> Wheelchair accessible	<input type="checkbox"/> Structured curriculum
<input type="checkbox"/> Preschool Program	<input type="checkbox"/> TV is not watched	<input type="checkbox"/> No pets at facility	<input type="checkbox"/> Has outdoor activities/equipment
<input type="checkbox"/> STARS to Quality Provider	<input type="checkbox"/> English as a Second Language		
<input type="checkbox"/> Summer Program			

Meals

What meals are provided?

<input type="checkbox"/> Breakfast	<input type="checkbox"/> Morning Snack	<input type="checkbox"/> Lunch	<input type="checkbox"/> Afternoon Snack	<input type="checkbox"/> Dinner
<input type="checkbox"/> Evening Snack	<input type="checkbox"/> Child Care Food Program	<input type="checkbox"/> OPI Afterschool Snack Program		

Philosophy

What is the philosophy you use?

<input type="checkbox"/> Faith based	<input type="checkbox"/> Montessori	<input type="checkbox"/> Waldorf	<input type="checkbox"/> Reggio Emilia	<input type="checkbox"/> Other
<input type="checkbox"/> Parent Cooperative (Facility is run by Parent Board.)				

Best Beginnings Child Care Scholarship

Do you accept the Best Beginning Child Care Scholarship? ☐ Yes ☐ No

Best Beginnings STARS to Quality

Do you participate in the STARS to Quality program? ☐ Yes ☐ No
If yes, what STARS level is your child care facility on? _____

Policies *Choose all that apply.*

<input type="checkbox"/> Yes <input type="checkbox"/> No	Separate sick area for children while waiting for parent to pick up
<input type="checkbox"/> Yes <input type="checkbox"/> No	Charges for absent days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Closed for vacations and sick days (closes facility when on vacation or sick)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Uses substitutes when absent (keeps facility open by using substitutes)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Charges for holidays when facility is closed

Special Skills

Does your child care facility provide any of the following special skills?

<input type="checkbox"/> Music	<input type="checkbox"/> Drama	<input type="checkbox"/> Art	<input type="checkbox"/> Sports	<input type="checkbox"/> Other
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Special Needs

What special needs experience does your child care facility have?

<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Autism	<input type="checkbox"/> Catheter	<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Vision Impaired	<input type="checkbox"/> Seizures	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Tube Feeding
<input type="checkbox"/> Asthma	<input type="checkbox"/> Developmentally Delayed	<input type="checkbox"/> Fetal Alcohol Syndrome	<input type="checkbox"/> Emotional/Mental Health	
<input type="checkbox"/> Medical Disability	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Cystic Fibrosis		

Professional Child Care Experience and Education

Please select a number of years for the Director of your child care facility.

<input type="checkbox"/> Under 1 year	<input type="checkbox"/> 1-3 years	<input type="checkbox"/> 4-9 years	<input type="checkbox"/> 10-20 years	<input type="checkbox"/> 21 years or plus
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Please list the educational background for the Director of your child care facility. _____

Professional Organization

Are you a current member of the following professional organization?

<input type="checkbox"/> MTAEYC	<input type="checkbox"/> MTCCA
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Facility Setting

What best describes your child care facility?

<input type="checkbox"/> Non-residential home	<input type="checkbox"/> Workplace based	<input type="checkbox"/> Mobile Homes	<input type="checkbox"/> Public/Private School
<input type="checkbox"/> Located in church	<input type="checkbox"/> Duplex	<input type="checkbox"/> Apartment	<input type="checkbox"/> Intergenerational
<input type="checkbox"/> Residential Home	<input type="checkbox"/> Franchise		

How did you learn about child care referral services? Please check all that apply.

<input type="checkbox"/> Employer	<input type="checkbox"/> Friend/relative	<input type="checkbox"/> Previous user	<input type="checkbox"/> Media-newspaper, radio, TV
<input type="checkbox"/> Brochure/Rack Card	<input type="checkbox"/> Community agency	<input type="checkbox"/> Tribal Program	<input type="checkbox"/> Phone book-Yellow Pages
<input type="checkbox"/> Child Care Provider	<input type="checkbox"/> Regional CCR&R Agency	<input type="checkbox"/> Internet/website	<input type="checkbox"/> State of Montana agency

Provider Statement

In your own words what do you want parents to know about your facility. (This is the exact text that will be available to parents on child care referrals.)

PLEASE INITIAL THE FOLLOWING STATEMENTS:

	I grant permission for my child care facility to be added to both the referral data base and online referral data base.
	I understand the preferred method of contact is email. If you indicate you have email address, this is what will be used to communicate with you.
	The following information will appear on the child care facility profile: First Name, Business Name, Address, City/State/Zip, Facility Type, Phone Number, Hours/Days, Ages Served, Map to Street, Rates, and Full/Part Time.
	I hereby affirm that the statements in the Provider Information Form are accurate, complete and true to the best of my knowledge.
	I agree to provide additional documentation concerning the Provider Information Form to the regional CCR&R agency at their request.
	I understand that the regional CCR&R agency 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 the regional CCR&R agency and to complete this form on an annual basis unless otherwise requested.

Provider Signature

Date