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.

☐Child Care Center ☐Family Child Care ☐Group Child Care ☐Tribal-Licensed Program
☐School Age Program ☐Preschool Program ☐Head Start/EHS ☐Family Friend Neighbor (FFN)
☐EHS Child Care Partner

CHILD AGES SERVED

Please check the age group served	*I do not have availability*	*I have Part Time availability*	*I have Full Time availability*
☐ Infants (0-23 months)	☐	☐	☐
☐ Toddlers (2 years old)	☐	☐	☐
☐ Preschool (3-5 years old)	☐	☐	☐
☐ School Aged (6 years old and older)	☐	☐	☐

Waiting List

Do you maintain a waiting list when you do not have vacancies? ☐Yes ☐No

Public School District

What school district is your program in, if applicable?

Transportation – *Choose all that apply.*

☐Yes ☐No Some type of transportation is provided.
☐Yes ☐No Child care facility is located near public transportation.

Languages

Do you speak any of the following languages? Multiple choices can be made.

☐English ☐Native American ☐Spanish ☐French
☐ German ☐American Sign Language ☐Other

Hours of Operation

Please list your facility's hours of operation:

Please check if you offer the following:
☐ Weekend Care ☐Evening Care

Is your facility open (check only one):
☐Full year ☐School year only ☐Summer only

Full-time and Part-time Attendance

Do you accept (check only one):
☐Full-time children ☐Part-time children ☐Both full-time and part-time children

Type of Child Care

Please check all that apply for type of care provided:
☐Drop-in ☐Temporary/Emergency (individual family emergency) ☐Before and/or After School ☐Rotating Shifts

Rates

Do you charge for any of the following: ☐Yes ☐No

Transportation	Minimum Daily Charge	Advanced Payment Required
Activity Fee	Absent Days	Holidays when the program is closed
Meal Fee	Registration Fee	Charges above the state rate
Other		

Attributes (Environment)

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

☐ Will toilet train	☐Offer field trips	☐ADA Compliant
☐Preschool/Pre-K Program	☐TV is not watched	☐ Structured curriculum
☐Summer Program	☐No pets at facility	☐ English as a Second Language

Meals

Do you provide meals?
☐Yes ☐No ☐CACFP Participant

Philosophy

What is the philosophy you use?
☐Faith based ☐Montessori ☐Waldorf ☐Reggio Emilia ☐Other
☐ 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? _____

Special Needs

What special needs experience does your child care facility have?

☐ADHD/ADD	☐Autism	☐Catheter	☐Downs Syndrome	☐Diabetes
☐Hearing Impaired	☐Vision Impaired	☐Seizures	☐Cerebral Palsy	☐Tube Feeding
☐Asthma	☐Developmentally Delayed		☐Fetal Alcohol Syndrome	☐Emotional/Mental Health
☐Medical Disability	☐Food Allergies	☐Cystic Fibrosis	☐Other:_____	

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