

Business Name _____

Contact Person _____

Street Address _____

City _____ Zip Code _____ County _____

Primary Phone Number _____ Secondary Phone Number _____

E-Mail Address _____ @ _____ Business Web Site _____

Referral Information Do you want your program to be referred to parents? (Circle one) Yes No
Do you want your program referred through Web Referrals? (Circle one) Yes No
If you do not want to be referred to parents, please give your reason _____

Do you want your rates printed? Yes No

License Information License ID Number _____ Expiration Date _____

License Type (Check all that apply) Day Overnight

Day Capacity Day-time licensed capacity _____ Desired capacity (if different) _____ Evening/Night capacity _____

Total Vacancies Days _____ Evenings/Nights _____ Ages Served From _____ to _____

School Information

Elementary school district you live in _____ District # _____

Elementary school(s) served _____

Transportation provided (provider or bus) Walking distance to school

Do you provide transportation? Will consider To/from home To/from school
 To/from activity To/from preschool To/from other

What languages are spoken in your home/program? English Spanish Native American African
 Asian European French Indian Other _____

Program Information Montessori Religious Content

Total number of staff _____

Days	Start Time	End Time
Monday	AM PM	AM PM
Tuesday	AM PM	AM PM
Wednesday	AM PM	AM PM
Thursday	AM PM	AM PM
Friday	AM PM	AM PM
Saturday	AM PM	AM PM
Sunday	AM PM	AM PM

<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Both
<input type="checkbox"/> Full Year <input type="checkbox"/> School Year <input type="checkbox"/> Summer Only
<input type="checkbox"/> Drop-in <input type="checkbox"/> Temp/Emerg. <input type="checkbox"/> Before School <input type="checkbox"/> After School <input type="checkbox"/> Rotating <input type="checkbox"/> 24 -hour <input type="checkbox"/> Open Holidays

Care Provided

Part day Part week Evening
 Weekend Overnight

Rate Information

	Infant - 6 weeks to 14 months	Toddler 1- 15 to 23 months	Toddler 2- 2 years	Preschool 1 - 3 and 4 years)	Preschool 2 - 5 years to Kindergarten	School Age - Before and After School	School Age - Vacation/ Summer/Holidays
Rate	\$	\$	\$	\$	\$	\$	\$
Rate Unit (circle one)	Hourly Daily Weekly Monthly Other	Hourly Daily Weekly Monthly Other	Hourly Daily Weekly Monthly Other	Hourly Daily Weekly Monthly Other	Hourly Daily Weekly Monthly Other	Hourly Daily Weekly Monthly Other	Hourly Daily Weekly Monthly Other
Full Time or Part Time? (circle one)	Full Time Part Time	Full Time Part Time	Full Time Part Time	Full Time Part Time	Full Time Part Time	Full Time Part Time	Full Time Part Time

Registration/Application _____ Deposit Required _____ Materials/Supplies _____

Additional Fees?

Field Trips Transportation Child Absent Fee Meal/Snack Fee
 Late Pick Up Charges CCAP Difference

Capacity and Vacancy Information

Age Group	Total Licensed Capacity	Days Full-time Vacancy	Days Part-time Vacancy	Evening/Night Full-time Vacancy	Evening/Night Part-time Vacancy	Special Needs Children Enrolled
Infant 6 weeks to 14 months						
Toddler 1 15 to 23 months						
Toddler 2 2 year old						
Preschool 1 3 to 4 yrs						
Preschool 2 5 years old and Kindergarten						
School-Age Before and After School						

Attributes

Please put an X in each box that pertains to your program/home.

Environment:

Smoke Free Fenced In Yard Wheelchair Accessible
 Pool Waterfront
 No Pets Indoor Pets Outdoor Pets
 Cat Dog

Meals

Provided:

USDA Food Program Breakfast AM Snacks
 Lunch PM Snacks Dinner
 Bring Own Meal/Snacks Special Diet

Financial Assistance Accepted:

IDHS Certificate DCFS Vouchers Multi-Child Discount

Policies:

May Give Rates Written Contract Written Policies
 Child absence rate/sick Child absence rate/vac & holiday Translated Materials
 Full Time Assistant Part Time Assistant

<u>Safety:</u>	<input type="checkbox"/> CPR	<input type="checkbox"/> First Aid	<input type="checkbox"/> On-site Nurse
<u>Special Needs:</u>	<input type="checkbox"/> Emotional/Behavioral	<input type="checkbox"/> Physical	<input type="checkbox"/> Developmental Delays
<u>Experience/</u>	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Asthma/Severe Allergies	<input type="checkbox"/> Visual/Hearing
<u>Training:</u>	<input type="checkbox"/> Sensory	<input type="checkbox"/> Special Health Needs	<input type="checkbox"/> Autism
	<input type="checkbox"/> Gifted	<input type="checkbox"/> Premature Infants	<input type="checkbox"/> Other _____
<u>Curriculum</u>	<input type="checkbox"/> arts/crafts/cooking	<input type="checkbox"/> music	<input type="checkbox"/> small and large motor skills
<u>Offered:</u>	<input type="checkbox"/> dram play/story time	<input type="checkbox"/> math/science	<input type="checkbox"/> field trips
	<input type="checkbox"/> outdoor play	<input type="checkbox"/> parent involvement	<input type="checkbox"/> computers

Comments: _____
