Attn: Rayma Ware

Solano Family & Children's Services

RESOURCE & REFERRAL PROVIDER DATA

_______________ Date

Please fill out this form TO BE LISTED IN OUR REFERRAL DATABASE OF CHILD CARE PROVIDERS.
Note: Please base your responses on the care you give on a regular basis.

Provider *(or Director)* First Name: ____________________________ Last Name: ____________________________

Business Name: ____

Type of Care: o Center o Family Child Care Home o Preschool Program o School-Age Program
o TrustLine (Family, Friend, & Neighbor) o Exempt Center o ASES Program

Physical Street Address: _____________________________________ City: ____________________ Zip: ________

Mailing Address (if different): __________________________________ City: ____________________ Zip: ________

Business Phone Number (______) ________ - _________ Other Phone Number (______) ________ - _________

E-mail Address: _________________________________ CA Workforce Registry # __________________________

Family Child Care License Number 48 _ _ _ _ _ _ _ _ _	**License Capacity** _ _	**Desired Capacity** _ _

CHILD CARE CENTERS ONLY		
INFANT License Number 48 _ _ _ _ _ _ _ _ _ _	**License Capacity** _ _	**Desired Capacity** _ _
PRESCHOOL License Number 48 _ _ _ _ _ _ _ _ _ _	**License Capacity** _ _ _	**Desired Capacity** _ _ _
SCHOOL AGE License Number 48 _ _ _ _ _ _ _ _ _ _	**License Capacity** _ _ _	**Desired Capacity** _ _ _

TOTAL Number of openings you currently have today, based on your **DESIRED** capacity: __________

Accepted Age Range (Youngest) ____________ (Oldest): ______________

What elementary school is nearest to your business? ____________________________________ (list one)

How do the children get between school and your program?

o Transportation Provided o Walking Distance to School o Near Public Transportation

o Near School Bus Route o On School Site o Provider Transports to children to and from the families home

Languages:
Please check all languages spoken fluently by anyone in the facility.

o English	o Spanish	o Chinese
o Tagalog	o Vietnamese	o Korean
o Arabic	o French	o German
o Hindu	o Italian	o Japanese
o Mandarin	o Portuguese	o Sign Language
o Thai	Other: ______________	

Please return this form to: Solano Family & Children's Services, 421 Executive Court North, Fairfield, CA 94534
If you have questions regarding this form, call the Resource & Referral Program staff at (707) 863-3950, ext.752

Education: o AA/BA/MA Degree, Child Related o CCIP Participant
o CDA (Child Development Associate Credential)

Do you offer a: o Religious Curriculum
o Montessori Curriculum

Accreditation: o NAFCC o NAEYC o NSACA o QRIS Rating

Days Care Provided	Start Time	End Time
o Monday		
o Tuesday		
o Wednesday		
o Thursday		
o Friday		
o Saturday		
o Sunday		

o Full Time (FT) ONLY	o Full Year
o Part Time (PT) ONLY	o School Year ONLY
o Both F/T and P/T	o Summer ONLY

o Drop In o Temp/Emergency
o Before School o After School
o Rotating o 24 Hour
o Open Holidays

Funding: o Head Start Funding o State Funding

Environment: o Pool o Pond o Indoor Pets o No Pets o Wheelchair Accessible
o Hot Tub o No pool/Hot Tub/Pond o Outside Pets o Liability Insurance o Smoke Free Environment (including non-business hours)

Meals: o Child Care Food Program (CCFP) o Breakfast o AM Snack
o Lunch o PM Snack o Dinner
o I am interested in joining the food program, or need additional information?

Special Needs Experience/Training:
(Please list if you have personal or professional experience or training in these areas)

o Behavioral/Emotional/Psychological o Special Health/Medical Need o Communication/Language
o Physical Disability o Visual/Hearing o Developmental Delays
o Developmental Disability o Learning Disability o Special Equip./Diet/Med's
o Other: ______________________

Thank you!