

CHILD CARE NEED FORM

In order to find the best match for you and your children's needs, please complete the following information. **A referral list of registered or licensed child care providers will be available within 2-5 working days.** The information provided is for referral purposes only. MT Child Care Resource & Referral agencies do not guarantee the information concerning any provider, nor do we license, endorse, or recommend any particular provider. Only you can determine whether the quality of care is appropriate for your child by thorough screenings and visits with the provider prior to enrolling your child.

Today's Date: _____ **Is this the first time you have received a referral? Yes No**

Parent(s) Name: _____

Street Address: _____ **City:** _____ **ST: MT Zip:** _____

County: _____

Mailing Address: _____ **City:** _____ **ST: MT Zip:** _____

Home phone: _____ **Work/other:** _____
Fax: _____ **E-mail:** _____ **Cell phone:** _____

Employed _____ **Unemployed** _____ **Student** _____
Employer: _____ **Spouse/partner's employer:** _____
Employer address: _____ **Employer address:** _____
Type of employment: _____ **Type of employment:** _____

Do you receive child care payment assistance?
 _____ Best Beginnings Scholarship _____ TANF _____ Tribal Block Grant _____ No assistance

Would you like information regarding child care payment assistance? YES NO

Care is requested:
 _____ Near home _____ Near work _____ Near parent school: _____
 _____ Near child's school _____ No preference _____ Other: _____

*If you would like to conduct an Internet referral on your own, please visit www.montanachildcare.org and click the **Search for Child Care Online** link. Log on with your email address. Your password will be your home phone number (xxx-xxxx format).*

Please complete the following information for all children needing child care:

Date care will begin: _____

Name of child needing care	Gender	Date of Birth	Days Care Needed	Times
1			M T W Th F Sa Su	
2			M T W Th F Sa Su	
3			M T W Th F Sa Su	
4			M T W Th F Sa Su	

Other scheduling needs, check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Full-time (30+ hrs/week)- | <input type="checkbox"/> Drop in care | <input type="checkbox"/> 24-hour care |
| <input type="checkbox"/> Part-time (less than 30 hrs) | <input type="checkbox"/> Before/after school care | <input type="checkbox"/> Temp./emergency care |
| <input type="checkbox"/> Full year care | <input type="checkbox"/> Rotating schedule | |
| <input type="checkbox"/> School year only | <input type="checkbox"/> Summer only | |

What type of care are you looking for?

- | | | |
|--|--|--|
| <input type="checkbox"/> Child Care Center (13 or more children) | <input type="checkbox"/> Family Child Care (3-6children) | <input type="checkbox"/> Preschool |
| <input type="checkbox"/> School Age Program | <input type="checkbox"/> Group Home Child Care | <input type="checkbox"/> Drop In Care |
| <input type="checkbox"/> (CCC) Tribal Licensed Program | <input type="checkbox"/> (7-12 children) | <input type="checkbox"/> Summer Program |
| | | <input type="checkbox"/> Unlicensed Ill Child Care |

What quality indicators would you like the facility to maintain?

Licensed/Registered 1-Star 2-Star No Preference

Do you have any Needs/ Preferences regarding Environment?

Provider will toilet train Offers field trips Wheelchair accessible
 No pets at facility Outdoor activities Uses a structured curriculum (preschool)
 Non smoking facility Outdoor play equipment No TV
 Does not use vehicle transportation

Do you need a provider who speaks a language other than English? (circle one) YES NO
If Yes, what language? _____

If you are you looking for a provider with special needs experience, please specify need: _____

Do you want your referral listing to include providers with waiting lists? YES NO

Who is providing your current care?

Family/group child care Child care center Head Start
 Family member Friend Nanny
 No current care Preschool LUP/LUI
 Before/after school program

What school does your child attend? _____

Transportation needs: (only if required)

I need child care to be walking distance from school I rely on public transportation
 I require transportation from provider

If you require transportation from your child care provider, please specify need:

To/from kindergarten Before/after school To/from child's activities
 To/from child's home

What is your family size? _____ _____ Single adult in household _____ Number of children
_____ Two or more adults in household

How did you learn about our services? Please check all that apply.

Employer Friend/relative Previous user
 Media-newspaper, radio, TV Brochure/poster Community agency
 Phone book-yellow pages Tribal program Internet/website
 Child Care Provider

What is your reason for seeking child care?

Work Looking for work School/training
 Respite care Child's need Parent's need
 Current care closing Asked to leave Unhappy with quality of current care
 Current cost too high

Would you like a personal consultation on selecting quality child care? YES NO
If yes, please see the receptionist to make an appointment.

Would you like any parenting or child development information? Please specify: _____

I would like to have my referral list: (check one)

I will pick it up. Please list date and time: _____
 Mailed to me at the address listed on the front.
 Please fax to the number listed on the front.
 E-mailed to me at the e-mail listed on the front.

For office use only:

Referral Counselor: _____

Date referral completed: _____