



Data Collection Form

Montana Early Childhood Account

Early Learning Development Support and Training Grant
For Licensed/Registered Family/Group/Center Child Care Providers

If you have questions or need help completing this Data Collection Form, please email the MECA Board at hhsmeCaboard@mt.gov.

SECTION 1. GENERAL PROVIDER INFORMATION

Child Care Program Name	(text box)		
Physical Street Address	(text box)		
City	(text box)	Zip Code	(text box)
Mailing Address (if different)	(text box)		
City	(text box)	Zip Code	(text box)
PV#	(numeric value)	County	(Select from list)
Owner/Director Name	(text box)	Please check the box if you are a new director/owner	☐
What type of provider are you? (select all that apply to this program)	☐ Family Child Care ☐ Group Child Care ☐ Center ☐ Early Head Start ☐ AIAN Early Head Start ☐ Head Start ☐ AIAN Head Start		
Is your Montana Child Care License/Registration current and in good standing?	☐ Yes ☐ No	If no, do you need assistance with licensing/registration?	☐ Yes ☐ No ☐ N/A

SECTION 2. LICENSED CAPACITY

For how many children is your program currently licensed or registered?	(numeric value)
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Current enrollment by age category				
Infants	Toddlers	Preschoolers	School Aged	Total
(numeric value)	(numeric value)	(numeric value)	(numeric value)	(numeric value)
Has your licensed capacity changed in the past year?		☐ Increase ☐ Stayed the same ☐ Decrease		
If there was a change in licensed capacity, please tell us the reason(s).		(text box)		
A. Is the program at full capacity?		☐ Yes (Continue to Section 3) ☐ No		
B. If your program isn't at full capacity, would you like it to be?		☐ Yes ☐ No (Skip to D)		
C. If you would like your program to reach full capacity, what support(s) would help?		(text box)		
D. If you are not at full capacity and do not wish to be, why?		(text box)		
SECTION 3: LICENSED CAPACITY				
Number of full-time employees (including self)	(numeric value)	Number of part-time employees	(numeric value)	
Is the program at full staffing?		☐ Yes ☐ No		
If not fully staffed, would you like to share reasons why (if known)?		(text box)		
Salary Range of staff, including self (per hour):				

Lowest salary (per hour)	(numeric value)	Highest (per hour)	(numeric value)
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Benefits: Select all that apply.

- | | |
|--|---|
| ☐ Health Insurance ☐ Vacation or Personal Time | ☐ Sick Time ☐ Free or Discounted Child Care for Staff
☐ Other: Describe below |
|--|---|

Other Benefits you provide to staff, if applicable:

(text box)

Section 4: Funding Summary

Please document the funding used in the last year for each funding category.

Program Expense	Amount
Technology Describe:	
Staffing Support Describe:	
Training Fees Describe:	
Other Describe:	
TOTAL:	

Section 5: Professional Development

Number of teaching staff who participated in approved training		Number of staff completing inclusion, behavior, emotional regulation, or family-support training	
Total professional development training/course hours completed		Number of Employees That Obtained Credentials	
Number of professional development trainings/courses completed		Number/percentage of staff trained in developmental screening	
Professional Development Technology Support			
Technology purchased with grant funds	☐ Yes ☐ No	Number of staff using grant-funded technology for training	

Section 6: Developmental Screening, Referral, and Resources

Did your facility implement a consistent developmental screening process?	☐ Yes ☐ No
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Number of children screened	
Number of screenings resulting in a referral	
Did your facility access SPARK or Zero to Five Montana for support?	
Provider Affirmation: I affirm that the information in this progress report is correct to the best of my knowledge.	
Signature: _____	Date: _____

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