Child Care Center

If you have questions, or need help in completing this application, call CCDF Administrator, Margaret Altvater 853-2600 ext.246 or email maltvater@wabanaki.com.

Section 1. General Applicant Information

Child Care Program Name:	Location Address: Location Zip Code:	Mailing Address:
State or Territory Licensing or Other Identifying Number:	☐ Licensed ☐ License Exempt	DUNS Number or Taxpayer ID Number:
Legal Business Name or DBA:		
Operator/Director Name:	Operator/Director Contact email:	Phone Number:

Operator/Director Race: ☐ American Indian/Alaska Native Indigenous ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Multiracial	Operator/Director Ethnicity: ☐ Latino ☐ Not Latino	Operator/Director Gender:

Section 2. Operational Status

What type of program do you operate? Select all that apply.

☐ Child Care Center

☐ State Prekindergarten

☐ Head Start

☐ Early Head Start

☐ School-Age Site (before- or afterschool, summer camp)

☐ Faith Based ☐ Other:
Was your program licensed/registered/certified/regulated on or before March 11, 2021? ☐ Yes ☐ No **OR** **Does your program meet Child Care and Development Fund health and safety requirements including the completion of comprehensive background checks?** ☐ Yes ☐ No
What is the current status of your program? ☐ Open ☐ Temporarily closed due to public health, financial hardship, or other reasons relating to the coronavirus disease 2019 (COVID-19) public health emergency. Please give details about the temporary closure and planned date to reopen:

Section 3. Child Count Information

What is the licensed or identified capacity of your program?	**Days of Operation:** **Hours of Operation:**
What is your current average enrollment by age: Infant: Toddler: Preschool: School Age: **Total:**	**Of the children enrolled, how many are funded by the following programs?** Early Head Start: Head Start: State Prekindergarten: **Total:**

Provider Statement: My estimated current monthly expenses are: $_____

Section Four: Current Average Monthly Operating Expenses

Allowable Expenses	**Average Monthly Cost**	
Payroll: (number of individuals [FTE] currently on payroll: _____)		
Benefits:		
Other Personnel Costs:		
Rent or Mortgage:		
Facility Expenses (Utilities, Insurance, Maintenance):		
Personal Protective Equipment (PPE), Including Cleaning and Sanitation Supplies and Services:		
Training Expenses for Staff on Health and Safety Practices:		
Equipment and Supplies in Response to COVID-19:		
Total:		
Additional Costs:		
Goods and Services to Maintain or Resume Services:	Amount:	Describe:
Mental Health Supports for Children or Staff:	Amount:	Describe:
Total:		
This is NOT the amount you will receive. The purpose is to calculate average monthly expenses.		

Section 5. Options for Use of Funds

Subgrant funds may only be used for the following categories. Please check the box and enter the estimated monthly amounts per category. Because this is an estimate, you can move funds between categories without prior approval. You may choose to use funds for one or more of the following:

☐ Personnel costs, benefits, premium pay, and recruitment and retention	Estimated Monthly Amount:
☐ Rent or mortgage payments, utilities, facilities maintenance and improvements, or insurance	Estimated Monthly Amount:
☐ PPE, cleaning and sanitation supplies and services, or training and professional development related to health and safety practices	Estimated Monthly Amount:
☐ Purchases of or updates to equipment and supplies to respond to COVID-19	Estimated Monthly Amount:
☐ Goods and services necessary to maintain or resume child care services (Describe: _____ _____)	Estimated Monthly Amount:
☐ Mental health supports for children and employees (Describe: _____ _____)	Estimated Monthly Amount:

Please indicate if you plan to use funds for any expenditures prior to March 11, 2021: Yes ☐ No ☐

Certification

To receive a stabilization grant, I agree to use the funds only for the categories and purposes indicated on this application and have marked above which categories I plan to fund. **Note:** You can move funds between categories without prior approval.

I also understand that it is my responsibility to maintain records and other documentation to support the use of funds I receive, as well as to document my compliance with the requirements described in A, B, and C.

By signing this application, I am certifying that I will meet requirements throughout the period of the subgrant, including the following:

A. When open and providing services, I will implement policies in line with guidance and orders from corresponding state, territorial, Tribal, and local authorities and, to the greatest extent possible, implement policies in line with guidance from the U.S. Centers for Disease Control and Prevention (CDC).

B. For each employee (including lead teachers, aides, and any other staff who are employed by the child care provider to work in transportation, food preparation, or other type of service), I must continue paying at least the same amount of weekly wages and maintain the same benefits (such as health insurance and retirement) for the duration of the subgrant. I understand that I may not

furlough employees from the date of application submission through the duration of the subgrant period.

C. I will provide relief from copayments and tuition payments for the families enrolled in the child care program, to the extent possible, and prioritize such relief for families struggling to make either type of payment.

Provider Affirmation

The following signature affirms that I will adhere to the items noted in A, B, and C. It also affirms I will only use the funds in the areas noted in section 5 of this application.

Provider Signature and Date: