

Absentee Shawnee Tribe of Oklahoma American Rescue Plan Act Stabilization Subgrant Application for Child Care Providers

Please complete all portions of the application; missing or omitted information may result in delays in application. For home providers, put N/A when sections are not applicable.

Section 1. General Application Information

Legal Business Name or DBA:		
Child Care Center Name:	Location Address (City, State, Zip):	Mailing Address (if different):
Tribal and/or State Licensing, or Other Identifying Number:	<input type="checkbox"/> Licensed <input type="checkbox"/> License Exempt Approved <input type="checkbox"/> Certified <input type="checkbox"/> Registered <input type="checkbox"/> Regulated	Employer Identification Number, or Taxpayer Identification Number, or DUNS Number:
Operator/Center Director Name:	Operator/Center Director Email:	Phone Number: Alternative Phone Number:
Operator/Center Director Race: American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian/Pacific Islander; White; Multiracial	Operator/Center Director Ethnicity: Latino or Not Latino	Operator/Center Director Gender:

Section 2. Operational Status

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

<input type="checkbox"/> Child Care Center	<input type="checkbox"/> Family Child Care Home
<input type="checkbox"/> State Prekindergarten	<input type="checkbox"/> Family Child Care Group Home
<input type="checkbox"/> Head Start	<input type="checkbox"/> In-Home Care (Special Services)
<input type="checkbox"/> Early Head Start	

School Age Site (before- or after school care, summer camp, language or culture 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 maximum licensed, identified or approved 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? Tribal CCDF: State CCDF: Early Head Start: Head Start: State Prekindergarten: Other (Please list): Total:

In January 2020, prior to COVID-19, what was your average enrollment by age?

Infant:

Toddler:

Preschool:

School Age:

Total:

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

Section 4. Current Average Monthly Operating Expenses

Allowable Expenses		Average Monthly Cost	
Payroll: (Number of individuals 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, Supplies, or Technology needed in Response to COVID-19:			
Total:			
Additional Costs:			
Good 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. 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 categories; please check the appropriate box(es) and enter the estimated monthly amount or total of reimbursable receipts per category.

<input type="checkbox"/> Personnel costs, benefits, premium pay, and recruitment and retention	Estimated Monthly Amount or Receipts Total:
<input type="checkbox"/> Rent or mortgage payments, utilities, facilities maintenance and improvements, or insurance	Estimated Monthly Amount or Receipts Total:
<input type="checkbox"/> PPE, cleaning and sanitation supplies and services, or training and professional development related to health and safety practices	Estimated Monthly Amount or Receipts Total:
<input type="checkbox"/> Purchase of, or updates to, equipment, supplies, or technology needed to respond to COVID-19	Estimated Monthly Amount or Receipts Total:
<input type="checkbox"/> Goods and services necessary to maintain or resume child care services. <i>Describe here:</i>	Estimated Monthly Amount or Receipts Total:
<input type="checkbox"/> Mental health supports for children and employees. <i>Describe here:</i>	Estimated Monthly Amount or Receipts Total:
<input type="checkbox"/> Construction or major renovation of facility.* <i>Describe needs in this area.</i>	Estimated Monthly Amount or Receipts Total:

**Indicating construction or major renovation needs does not guarantee funding will be available. In accordance with review and approval processes, any request for construction or renovation project funding must be approved through the Tribal Lead agency by the Office of Child Care before funding can be spent.*

Please indicate if you plan to use funds for any expenditure prior to March 11, 2021:

_____ Yes _____ No

Please indicate if this application is for reimbursement of expenses:

_____ 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 to pay 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 area noted in section 5 of this application.

Provider Signature and Date:

For CCDF Staff Use:

Received:

Reviewed by:

Approval Date:

Denial Date: