**Tolowa Dee-ni' Nation**
**Department of Community & Family Wellness**
**140 Rowdy Creek Road, Smith River, CA 95567**
**Telephone (707) 487-9255 ext. 1402 Fax (888) 886-4306**

# ARPA Child Care Stabilization Grant Application

| **Section 1 General Applicant Information** | | |
|---|---|---|
| Child Care Center/Provider Name: | Child Care Center/Provider Location Address: | |
| Operator/Owner Director Name: | Mailing Address: | |
| Contact Phone: | Contact Email: | |
| Operator/Center Licensing Status: ☐ Licensed ☐ License Exempt ☐ Certified ☐ Registered ☐ Other: _____ | | State & License Number: _____ License Effective Date: _____ |
| Director/Owner Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Multiracial | | Director/Owner Ethnicity: ☐ Latino ☐ Non-Latino |
| Director/Owner Gender: ☐ Female ☐ Male ☐ Non-Binary | | |

| **Section 2 Operation Status** |
|---|
| Type of Provider: ☐ Child Care Center ☐ Family Child Care Home ☐ Head Start/Early Head Start ☐ School-Age Site (before/after school care, summer or language camp) ☐ Other: _____ |
| Was your program licensed/registered on or before March 11, 2021? ☐ Yes ☐ No<br>***Or***<br>Does your program meet the Child Care and Development Fund health & safety requirements, including comprehensive background checks? ☐ Yes ☐ No |
| What is the current status of your program?<br>☐ Open<br>☐ Temporarily closed related to COVID-19/Public Health<br>(If temporarily closed, please indicate the date of anticipated reopen): _____<br>☐ Closed *(Ineligible)* |

## Section 3 Child Count Information

Do you currently provide child care to at least one child that meets the definition of "Indian Child" per (Tolowa Dee-ni' Nation's (TDN) CCDF Plan (see below)?

☐ Yes

☐ No *(Ineligible)*

***Curry County-Oregon***

A child from 0-13 years of an enrolled Tribal citizen of a federally recognized tribe or a child of an enrolled member of federally recognized tribe.

***Del Norte and Humboldt County-California***

A child from 0-13 years, who is an enrolled member of Tolowa Dee-ni' Nation (TDN) or is the child of an enrolled member of TDN by blood, court decree or marriage.

Do you provide care to infants, toddlers, non-standard hours or children with special needs?

☐ Infants/toddlers
☐ Non-standard hours
☐ Special needs
☐ N/A

What is the maximum licensed, identified or approved capacity of your program? _____

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|---|---|
| What is your current average enrollment by age: | Infant: _____<br>Toddler: _____<br>Preschool: _____<br>School age: _____ |
| In January 2020, before COVID-19, what was your average enrollment by age? | Infant: _____<br>Toddler: _____<br>Preschool: _____<br>School age: _____ |

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| Of the children enrolled, how many receive a subsidy from these programs? | Tribal CCDF: _____<br>State CCDF: _____<br>Other: _____<br>☐ None |

| Section 4 Current Average Monthly Operating Expenses* | |
|---|---|
| Allowable Expenses | Monthly Expense/Cost |
| Payroll (total # of people currently on payroll _____): | $ |
| Benefits: | $ |
| Other Personnel Costs: | $ |
| Rent or Mortgage: | $ |
| Facility Expenses (utilities, insurance, maintenance): | $ |
| Personal Protective Equipment (PPE) including cleaning/sanitizing supplies & services: | $ |
| Training expenses for staff on Health and Safety practices: | $ |
| Equipment and supplies in response to COVID-19: | $ |
| Other Allowable Expenses | Monthly Expense/Cost |
| Goods and services (including food) to maintain or resume services: (Describe below) | $ |
| Describe Goods & Services: | |
| Mental health supports for children or staff: | $ |
| **This is **NOT** the amount you may be eligible to receive. This data will be used to determine average monthly expenses and to determine subgrant award.* | |
| Additional funding may apply if documentation is provided to support these expenses. Any receipts must be kept for a minimum of 3 years after the subaward period. | |

| Section 5 Options for Fund Use |
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| ☐ Check this box if you plan to use any funds to reimburse yourself for expenses incurred after the public health emergency in January 2020, if you are awarded a subgrant. |
| ☐ Check this box if you only plan to use funds for current expenses, indicate which expenses:<br>☐ Payroll Benefits ☐ Other Personnel Costs ☐ Rent or Mortgage ☐ Facility expenses<br>☐ Personal Protective Equipment ☐ Training Expenses for Staff on Health & Safety Practices<br>☐ Equipment and Supplies in Response to COVID-19 ☐ Other Allowable Expenses |

| Section 6 CERTIFICATION | | | |
|---|---|---|---|
| To receive a stabilization subgrant, 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.* | | | |
| | **Provider Initial** | _____ | |

**Section 6 Certification continues on next page.**

| | | | |
|---|---|---|---|
| I understand that it is my responsibility to maintain receipts/records and other documentation to support the use of funds I receive for 3 years, as well as to document my compliance with requirements A, B & C listed below: | | | |
| Requirement 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 extent possible, implement policies in line with guidance from the US Center for Disease Control and Prevention (CDC) | | |
| | **Provider Initial** | _____ | |
| Requirement B | For each employee (including lead teachers, aides and other staff who are employed by the child care provider to work in transportation, food preparation or other type of services), 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. | | |
| | **Provider Initial** | _____ | |
| Requirement 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 Initial** | _____ | |

| **Provider Signature** |
|---|
| **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 Printed Name: |
| Signature of Provider: Date: |

***For Official Use Only***

| | | |
|---|---|---|
| □ Approved | Approved by: | Date: |
| □ Denied | Denial Reason: □ Incomplete App. □ Ineligible □ Other | |
| Grant Information: | | |