Scotts Valley Band of Pomo Indians
1005 Parallel Drive, Lakeport CA 95453
PHONE 707-263-4220 FAX 707-263-4345

Child Care Stabilization Grant Application

Child Care Center Name:	**Location Address:**	**Mailing Address (if different)**
Tribal and/or State Licensing or other Identifying Number:	☐Licensed ☐License exempt ☐Approved ☐Certified ☐Registered ☐Regulated	**Employer Identification Number or Taxpayer Identification or DUNS Number:**
Operator/Center Director Name:	**Operator/Center Director Contact Email:**	**Phone Number:** **Alternate Number:**
Operator/Center Director Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Multiracial	**Operator/Center Director Ethnicity:** ☐Latino ☐Not Latino	**Operator/Center Director Gender:** ☐Male ☐Female ☐Non-binary

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 after-school care, summer camp, language or culture camp)

☐Faith Based

☐Other (explain)

_____

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:

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, before COVID-19, what was your average enrollment by age? Infant:_____ Toddler:_____ Preschool:_____ School Age:_____ ***Total***:_____	
Provider Statement: My estimated current monthly expenses are $_____	

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

Subgrant funds may only be used for one or more of the purposes below. Please indicate which categories you will support with the funding received from the subgrant:

☐Personnel costs, benefits, premium pay, and recruitment and retention.

☐Rent or mortgage payments, utilities, facility maintenance and improvements, or insurance.

☐Personal protective equipment, cleaning and sanitation supplies and services, or training and professional development related to health and safety practices.

☐Goods or services necessary to maintain or resume child care services.

☐Purchases of, or updates to, equipment or technology needed to respond to COVID-19.

☐Mental health supports for children and employees.

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 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 sectio9n 5 of this application.

_____ _____

Provider Signature Date