**Home-Based Child Care Provider COVID-19 Rapid Response Application**

*Note: Red text offers guidance to the intermediary or indicates areas for local customization.*

***Provider/Organization***

|  |  |
| --- | --- |
| **Applicant Information** |  |
| Provider/Organization Name: |  |
| Legal Entity Name (if different from above): |  |
| Employer Identification Number -EIN (if you have one): |  |
| Date Established: |  |
| Address: |  |
| Address 2: |  |
| City: |  |
| State: |  |
| Zip Code: |  |
| **Primary Contact Information** |  |
| First Name: |  |
| Last Name: |  |
| Email: |  |
| Phone: |  |
| Address (if different from above): |  |
| Address 2: |  |
| City: |  |
| State: |  |
| Zip Code: |  |

1. Legal entity type (For-profit/Non-profit)
2. What type of provider are you (Home/Expanded Home/Group)
3. What is your current licensed capacity [across all sites] according to your facility [State licensing entity] license(s)?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | Address 1 | Address 2 | City | ST | Zip | Licensed Capacity | Do you rent or own? | QRIS Rating |
|  |  |  |  |  |  |  |  |  |

1. Who are you currently serving and what are your current funding sources? Please fill out the following table below including totals per age level based on enrollment as of [Guidance: consider a lookback date appropriate to your local context – should reflect a time where average enrollment was representative of operations prior to the effects of COVID-19] date, along with breakdown by funding source. Please share enrollment, counting each child only once (for children receiving funding from multiple sources, designate them in the primary funding category).

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Total Enrolled | Private Pay | [CCDBG Subsidy Program] | [Locally Funded PreK] | [State Funded PreK] | Early Head Start | Head Start | Out of School Time | Other |
| Infant |  |  |  |  |  |  |  |  |  |
| Toddler |  |  |  |  |  |  |  |  |  |
| Preschool |  |  |  |  |  |  |  |  |  |
| School-Age |  |  |  |  |  |  |  |  |  |

*\*\* We reserve the right to check your compliance status with any of the above programs*

1. Do you serve any special populations (please provide # of children falling into this category)? *\*Guidance: alter these categories and definitions based on location.*

|  |  |
| --- | --- |
| **Special Populations** | **# of Children** |
| Medically fragile conditions |  |
| Special needs or developmental delays |  |
| English language learners |  |
| Immigrant/immigrant families |  |
| Physically disabled |  |
| Behavioral/early childhood mental health needs |  |
| Living in a shelter, transitional, or temporary housing |  |
| Other (please describe) |  |

1. Are you currently engaged in quality improvement activities or technical assistance? [Guidance: offer as a drop-down and/or narrative]
2. Do you currently participate in the Child and Adult Care Food Program (CACFP)? (Y/N)
3. Are you currently open or closed? (Open/Voluntary Closure/Mandated closure/Essential workers) [if Open –question series can pop asking about current enrollment/attendance]

***Staffing & Economic Impact***

1. Do you have additional staff besides yourself (please include assistants and substitutes)? (Y/N) [Guidance: If no, skip to “Funding Needs/Request” category.]
2. Do you currently have an employee sick leave policy in place and offer paid sick leave to your staff? (Yes/No)
3. Do you employ additional staff? (If yes, please complete the chart below, enter data as of Lookback Date suggested above)

|  |  |
| --- | --- |
|  | # (full-time or part-time) |
| Directors/owners (include yourself) |  |
| Teaching staff (including assistants) |  |
| Substitutes |  |
| Bookkeeper |  |
| Other |  |

1. What is the current qualification of you and your staff?

|  |  |  |
| --- | --- | --- |
| Level | Provider | Assistant/Other Staff |
| Child Development Associate (CDA) |  |  |
| Associate’s Degree |  |  |
| Bachelor’s Degree |  |  |
| Other (please describe) |  |  |

* What was your annual income from your HBCC operation in the past year?
* How much did you spend on compensation or salary for your employees in the past year? (If you pay yourself a salary, please also include your salary in the response.)

***Funding Needs/Request***

1. What are your financial concerns?

[Guidance: have as a “check all that apply” or prioritize for ongoing needs assessment or post-event reporting purposes, etc.)

* Housing Support (Rent/mortgage)
* Utilities
* Paid sick leave for self or staff
* Paying for substitutes
* Lost income (replace co-pays, private pay, or other funding sources)
* Additional costs for cleaning and sanitizing, or health and safety materials
* Increased cost of food
* Increased compensation for hazard pay
* Professional service needs – legal, HR, etc.
* Reopening costs
* Marketing/communication of open/closed status
* Immediate need for professional development, training or consultation
* Other [text box]

1. How do you anticipate you will use the proposed funds?

|  |  |  |
| --- | --- | --- |
| **Budget Category** | **Check items you will address with grant funds** | **Description or estimated $ amount (optional)** |
| Housing support (rent/mortgage) |  |  |
| Utilities |  |  |
| Paid sick leave for self or staff |  |  |
| Pay for substitutes |  |  |
| Lost income (replace co-pays, private pay, or other funding sources) |  |  |
| Cleaning and sanitizing, or health and safety materials |  |  |
| Food |  |  |
| Increased compensation for hazard pay |  |  |
| Professional service needs – legal, HR, etc. |  |  |
| Reopening costs |  |  |
| Marketing/communication of open/closed status |  |  |
| Professional development, training, consultation |  |  |
| Other (please explain) |  |  |

***Narrative***

1. What else should we know about this program, your organization, and the landscape in which you work? [250 words]

***Attestation***

Applicant is in compliance with the following (please note, by checking each box you are indicating that as of date of application submission, you are in full compliance with the following criteria):

* Holds current insurance coverage as required by local licensing/regulatory authority
* Is current on all local, state and federal taxes (and/or is under payment plan)
* You and your staff have active background checks as required by local licensing and regulatory authorities
* You intend to stay in business for the foreseeable future and after the conclusion of COVID-19
* You can meet the obligations set forth in the grant agreement

***Optional Questions (for data collection purposes only)***

* Is your business owned or controlled by a person or people of color? (Answer “yes” if more than half of the owners identify as Hispanic or a race other than White)
* Is your business owned or controlled by a women? (Answer “yes” if at least half of the owners identify as women)
* Is your business owned or controlled by individuals with gross annual household incomes at $59,172 per year or below? (Answer “yes” if more than half of the owners have gross annual household incomes at or below $59,172 per year)

[Guidance: Alternate question for race/gender]

Please check all that apply. This is for data collection only.

* African-American owned business
* Latinx-owned business
* Asian-American owned business
* LGBTQ-owned business
* Woman-owned business
* White-owned business
* Disabled-owned business
* Veteran-owned business
* Immigrant-owned business
* Other minority owned business

***Document Submissions***

1. Childcare license(s)
2. Organizational Document (501c(3), EIN)
3. Attendance record or copy of contract or service agreements indicating service to subsidized populations [Not required if intermediary is able to validate this on their own]
4. W-9
5. Direct deposit (ACH) info [W9 and ACH not necessary if already set up as a vendor on file]