**Family, Friend and Neighbor** ECE COVID-19 Rapid Response Application

FFN caregivers and providers may not identify themselves as such. Depending on your target caregiver/provider, use the appropriate language to speak directly to them in this application.

***Caregiver***

1. Your name:
2. Address [consider carefully if you need address information as some populations may be nervous to share this information including those that are housing insecure, victims of crimes, undocumented immigrants, etc]
3. Address 2
4. City
5. State
6. Zip Code
7. Email:
8. Phone:
9. How long have you been providing child care? Consider only children that you care for over 10 hours a week. Date started:
10. How many children do you care for, how old are they, and what is their relationship to you? How many hours of care do you provide per week? Please do not share any names of children.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Age | Relationship [drop down: child, grandchild, niece/nephew, neighbor, other] | Hours of care per week. |
| Child 1 |  |  |  |
| Child 2 |  |  |  |
| Child 3 |  |  |  |
| Child 4 |  |  |  |

1. Do the parents of the children you serve work in jobs considered essential during the COVID-19 crisis (health care, food service, grocery store, gas station, mail and delivery, etc). YES/NO. Tell us a little more about their child care needs during this time.
2. Have you seen any change in need for child care during this crisis? Check those that apply
   * Parents need longer hours of care
   * New/other parents need me to look after their children
   * Parents need less care because they are not working
   * There has been no change
3. Are you paid for providing child care? YES/NO
4. Do you receive payments from the state or parents? STATE/PARENTS/BOTH
5. About how much do you earn a week?
6. Do you care for any children or families with the following needs:

|  |  |
| --- | --- |
| **Special Populations** | **# of Children** |
| Medically fragile conditions (e.g. feeding tube) |  |
| Special needs or developmental delays |  |
| English language learners |  |
| New American/immigrant families |  |
| Physically disabled |  |
| Behavioral/mental health needs |  |
| Living in a shelter, transitional, or temporary housing |  |
| Other (please describe) |  |

1. Do you currently participate in the Child and Adult Care Food Program (CACFP)? (Y/N)
2. Do you have helpers who support your in providing care to young children (please include assistants and substitutes)? (Y/N)

***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
* Paying for substitutes
* Lost income (because parents can’t pay or state subsidies stop)
* Additional costs for cleaning and sanitizing, or health and safety materials
* Increased cost of food
* Need to work for more hours without additional pay
* Professional service needs – legal, HR, etc.
* Other [text box]

1. How will you use emergency funds?

|  |  |  |
| --- | --- | --- |
| **Budget Category** | **Check items you will address with grant funds** | **Description of funds (optional)** |
| Housing support (rent/mortgage) |  |  |
| Utilities |  |  |
| Paid sick leave for self |  |  |
| Pay for substitutes |  |  |
| Lost revenue (parent or state payments) |  |  |
| Cleaning and sanitizing |  |  |
| Food |  |  |
| Professional service needs – legal, HR, etc. |  |  |
| Other (please explain) |  |  |
|  |  |  |
|  |  |  |

Narrative: What else should we know about you, the families you care for, and the community in which you live? [250 words]

Attestation:

Please check each box to indicate that as of date of application submission, you agree with the statement.

* You currently or until COVID-19 provided 10 hours or more of care for young children in your community.
* You intend to continue to care for young children for the foreseeable future and after the conclusion of COVID-19.
* You are willing to let us know how you used the funds provided to you in this grant.

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

* Are you a person of color? (Answer “yes” if Hispanic or a race other than White)
* Are you a women?
* Is your gross annual household income at $59,113 per year or below?

[Guidance: Alternate question for race/gender]

Optional. Do any of the following describe you. This is for data collection only.

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

***Document Submissions***

* + 1. W-9
    2. Direct deposit or preferred payment approach info [W9 and ACH not necessary if already set up as a vendor on file]