CNMI CCDF ARPA Phase 1 (Operations Only) Application Child Care Provider: Budget Requested

If you have questions, or need help in completing this application, please contact Ms. Nadia Camacho, Grant Manager, at (670) 286-3211 or nadiacnmi@gmail.com.

Section 1. General Applicant Information

Child Care Program/Owner Name:	Location Address:	Mailing Address: City State Zip
CCLP License Number:	☐ Licensed ☐ License Exempt	CNMI Taxpayer ID Number:
Legal Business Name or DBA:	Federal Employer ID Number (EIN):	
Operator/Director Name:	Operator/Director Contact email:	Phone Number:

Operator/Director Race: American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian/Pacific Islander; White; Multiracial	Operator/Director Ethnicity:	Operator/Director Gender:

Section 2. Operational Status

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

☐ Licensed Child Care Center – CCDF Certified

☐ Licensed Child Care Center – not CCDF Certified

☐ Friend, Family, Neighbor Care (LEFFN)

☐ School-Age Site (before- or afterschool, summer 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? This should be completed by July 30, 2021 to qualify for funding. Failure to comply will result in disqualification or non-acceptance of future applications.

☐ 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:

Did your program receive any of the following supports*?	**How much funds were received?**	**What months were the fund support applied to?**	**What activities did the funds support?**
Payroll Protection Program (PPP)			
Pandemic Unemployment Assistance (PUA)			
Public School System (PSS)			
Coronavirus Aid, Relief, and Economic Security (CARES) Act			

***Attach supporting documents that show what the funding was used for, for whom, when, and what activities (e.g. payroll, bonus).

Section 3. Child Count Information

What is the licensed or identified DPW capacity of your program?	**Days of Operation:** **Hours of Operation:**
What is your current TOTAL enrollment by age (CCDF and non-CCDF children): Infant: Toddler: Preschool: School Age: **Total:**	**Of the children enrolled, how many are funded by the following programs?** Head Start: CCDF: **Total:**

What was your average enrollment by age between October to December 2019, before COVID-19 (CCDF and non-CCDF children)?

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 [FTE] 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 and Supplies in Response to COVID-19:		
Goods and Services to Maintain or Resume Services:	Amount:	Describe:

Allowable Expenses	Average Monthly Cost
Total:	
This is NOT the amount you will receive. The purpose is to calculate average monthly expenses.	

Section 5. Past Average Monthly Operating Expenses: January 31, 2020 to May 31, 2021

Allowable Expenses	Average Monthly Cost
Payroll: (number of individuals [FTE] 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 and Supplies to Support Health and Safety Practices	
Goods and services to maintain services	
Total:	

Please indicate if you plan to use funds for any expenditures prior to June 1, 2021: Yes ☐ No ☐

Certification

Initial on each line to show you have fully read and understood each statement.

_____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:** Notice must be given to the Grant Manager regarding movement of funds between catergories.

_____I 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 below.

_____By receiving stabilization funding, I agree to submit to an audit by any auditor of CCDF's choosing. I will grant the auditor access to and the right to examine and copy any records, data or papers relevant to this subgrant until three (3) years have passed since the final payment pursuant to this subgrant.

_____The undersigned being warned that willful false statements and the like are punishable by fine or imprisonment, or both under 18 USC 1001, and that such willful false statements and the like may jeopardize the validity of the application of document or any registration resulting therefrom declares that all statements made of his/her knowledge on this application are true and all statements made on information and belief are believed to be true.

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. I will not reduce wages regardless of children's enrollment/attendance.

C. _____I will provide relief from 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 areas noted in sections 4 and 5 of this application.

Provider Signature and Date: