

CENTER AND SCHOOL-AGE GRANT APPLICATION

CCR&R Northeast District/Region 7E

APPLICATION COVER SHEET, FORM 1

Please type or print clearly in ink.

Contracting Agency (Your agency's legal name and full address)	Director's Name
	Director's Signature
	Director's Phone Number (include Area Code)
	Fax Number (include Area Code)
	Director's E-Mail Address
Contact Mailing Address (If different from above)	Contact Name
	Contact's Phone Number (include Area Code)
	Contact's Fax Number (include Area Code)
	Contact's E-Mail Address
	County

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APPLICATION COVER SHEET, FORM 1, continued

Organizational Status (✓) <input type="checkbox"/> 501 (c) 3 <input type="checkbox"/> Public Agency <input type="checkbox"/> Unit of Government <input type="checkbox"/> For-profit Agency <input type="checkbox"/> Other:	DHS Licensor Name	In the past 4 years, how many years have you been awarded a grant? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4																				
	Center License Number																					
	Minnesota Tax Identification Number																					
	Federal Employer Identification Number																					
Program Hours Offered <table border="1"> <thead> <tr> <th>Days</th> <th>Hours</th> </tr> </thead> <tbody> <tr><td>Sunday</td><td>_____</td></tr> <tr><td>Monday</td><td>_____</td></tr> <tr><td>Tuesday</td><td>_____</td></tr> <tr><td>Wednesday</td><td>_____</td></tr> <tr><td>Thursday</td><td>_____</td></tr> <tr><td>Friday</td><td>_____</td></tr> <tr><td>Saturday</td><td>_____</td></tr> <tr><td>Holidays</td><td>_____</td></tr> <tr><td>Summer SAC Care*</td><td>_____</td></tr> </tbody> </table>	Days	Hours	Sunday	_____	Monday	_____	Tuesday	_____	Wednesday	_____	Thursday	_____	Friday	_____	Saturday	_____	Holidays	_____	Summer SAC Care*	_____	Program/Service (✓) <input type="checkbox"/> Child Care Center <input type="checkbox"/> Pre/Nursery School <input type="checkbox"/> School-age Care <input type="checkbox"/> Head Start <input type="checkbox"/> ECFE/ECSE <input type="checkbox"/> Employer/Church-Based Rule 2 <input type="checkbox"/> Other:	Grant Purpose (✓) Check each purpose for which you are applying for funds <input type="checkbox"/> Learning Environment <input type="checkbox"/> Health and Safety <input type="checkbox"/> Professional Development Number of Years of Operation _____
Days	Hours																					
Sunday	_____																					
Monday	_____																					
Tuesday	_____																					
Wednesday	_____																					
Thursday	_____																					
Friday	_____																					
Saturday	_____																					
Holidays	_____																					
Summer SAC Care*	_____																					
Grant Funds Requested by Category:																						
Grant Type	Total Funds Requested	Maximum You May Request																				
Learning Environment	\$ _____	\$2500.00																				
Health and Safety	\$ _____	\$2500.00																				
Professional Development	\$ _____	\$2500.00																				
Total Grant Funds Requested	\$ _____	\$3000.00 Maximum total of all grant types.																				

* School-age care (SAC) programs applying for grant funds must list the hours they provide care during the summer months.

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PROGRAM OVERVIEW (NARRATIVE), FORM 2

Since grant reviewers may not be familiar with your program, provide a complete description of the child care services you offer. State whatever information you think is important for reviewers to know to understand your grant proposal and your program.

1. What is the history of your program?

2. What is the mission of your program?

3. What are your goals for your program for the next year?

4. Is your program accredited?

_____ Yes Date accredited: _____ *Attach a copy of your Accreditation Certificate.*

_____ In the process of being accredited or re-accredited

_____ No

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PROGRAM OVERVIEW (NARRATIVE), FORM 2, continued

5. Provide your current enrollment information by completing the following table:

Age Category	Licensed Capacity*	Current Enrollment	Staff / Child Ratio	Number on Waiting List	Fee (full-time, weekly)
Infants					
Toddlers					
Preschool					
Kindergarten					
School-age					
TOTAL					

* Not applicable to legally exempt school-age care programs. Licensed capacity applies to Rule 3 and Rule 2 employer/church-based child care programs.

6. If known, the total number of children enrolled in your program who meet one or more of the following. Do not count the same child more than once. Note: you do not have to indicate the number of children in each category.

- * Speak English as a second language
- * Have an Individualized Education Program (IEP) through Early Childhood Special Education (ECSE)
- * Have an Individual Family Service Plan (IFSP)
- * Are enrolled in the Child Care Assistance Program (CCAP)
- * Are enrolled in the Minnesota Family Investment Program (MFIP)
- * Are enrolled in the Free or Reduced Lunch Program or are eligible for the free and reduced lunch program
- * Are enrolled in Head Start
- * Live in an out-of-home placement (e.g., foster care)

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_____ Total number of children who fit into one or more of the above

7. Describe the changes in your enrollment during the last two years (i.e., decreasing, increasing):

8. List the number of staff currently employed by your program.

_____ Full-time _____ Part-time (less than 30 hours/week)

9. List the number of your staff who have been employed by your program for the following lengths of time:

_____ 0 – 1 years _____ 1 – 3 years _____ 3 – 5 years _____ 5 – 10 years _____ More than 10 years

10. Describe your strategies for increasing staff retention.

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COMMUNITY OVERVIEW (NARRATIVE), FORM 3

1. Provide a clear description of the community you serve. Include information about the geographic area, population and any underserved communities in your service area.

2. What are some of the needs related to child and/or school-age care that are found in your community? If possible, provide data relevant to the problems facing the community.

3. Give a detailed description of how your program is able to respond to the needs of the community. Include a description of how you provide services to the underserved communities identified above.

4. Describe how your child care services will be available to families who are non-English speaking or speak English as their second language.

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GRANT REQUEST (ITEMIZED LISTS), FORM 4

Grant Type: Learning Environment

Attach additional sheets if necessary.

Items Requested	Amount	Check which group of children each item serves.		
		Infant/ Toddler ()	School-age Care ()	Preschool ()
Salary and Benefits (describe in detail including name, position, monthly salary, and benefits)	\$			
Equipment (itemize)	\$			
Supplies (itemize)	\$			
Contracted Services (describe in detail, including frequency of services)	\$			
Items Which Increase the Capacity of Culturally Responsive Services (itemize)	\$			
Other Expenses (itemize)	\$			
Total Amount Requested (may not exceed \$2500.00) Please copy this amount to Grant Funds Requested by Category on the Application Cover Sheet, Form 1.				
Date for all spending to be completed: April 15, 2012				

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GRANT REQUEST (ITEMIZED LISTS), FORM 4 continued

Grant Type: Health and Safety

Attach additional sheets if necessary.

Items Requested	Amount	Check which group of children each item serves.		
		Infant/ Toddler ()	School-age Care ()	Preschool ()
Salary and Benefits (describe in detail including name, position, monthly salary, and benefits)	\$			
Equipment (itemize)	\$			
Supplies (itemize)	\$			
Contracted Services (describe in detail, including frequency of services)	\$			
Items Which Increase the Capacity of Culturally Responsive Services (itemize)	\$			
Other Expenses (itemize)	\$			
Total Amount Requested (may not exceed \$2500.00) Please copy this amount to Grant Funds Requested by Category on the Application Cover Sheet, Form 1.				
Date for all spending to be completed: April 15, 2012				

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GRANT REQUEST (ITEMIZED LISTS), FORM 4 continued

Grant Type: Professional Development

Attach additional sheets if necessary.

Items Requested	Amount	Check which group of children each item serves.		
		Infant/ Toddler ()	School-age Care ()	Preschool ()
Salary and Benefits (describe in detail including name, position, monthly salary, and benefits)	\$			
Equipment (itemize)	\$			
Supplies (itemize)	\$			
Contracted Services (describe in detail, including frequency of services)	\$			
Items Which Increase the Capacity of Culturally Responsive Services (itemize)	\$			
Other Expenses (itemize)	\$			
Total Amount Requested (may not exceed \$2500.00) Please copy this amount to Grant Funds Requested by Category on the Application Cover Sheet, Form 1.	\$			
Date for all spending to be completed: April 15, 2012				

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BUDGET INFORMATION, FORM 5

A 25 percent local match is required on all grant requests. Sources of match funds may be cash or in-kind. An in-kind match can be donated materials or volunteer time. Fair market value of services and materials should be used when calculating the value of an in-kind match. Following is an *example* of how the match requirement could be met:

Total Grant Request = \$10,000

Match Requirement = \$2,500

Total Cost = \$12,500

Your request is for \$10,000 to develop a new, safe playground space. Parents will volunteer their time to help clear the space for the new equipment and safe surfacing. Ten volunteers at \$15 per hour, working for ten hours, would contribute \$1,500. Your program will hold a fundraiser to collect the \$1,000 necessary to pay the shipping and handling charges for the new equipment. Your 25 percent match is met.

List all sources that will assist your program in meeting the 25 percent match requirement.

Match Type	Amount	Source
In-Kind Contributions (Donated materials and/or volunteer time)	\$	
Cash (Cash that the program will contribute)	\$	
Other Grants (You may not use other state grant programs to meet this requirement)	\$	
Fees for Service (Activity fees charged to parents)	\$	
Other (explain)	\$	
Total Match Amount	\$	

1. **Would you accept a reduced level of funding for your requests?**

_____ Yes If yes, at what level would you still be able to implement your requests for each area? \$ _____

_____ No

2. **What would the impact of reduced funding be on your program?**

3. **What is the total annual budget for your program? \$ _____**

4. **What percent of your annual budget would this grant provide? _____%**

If the grant request exceeds 15% of your total annual budget, you must complete Form 7.

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GRANT REQUEST (NARRATIVE), FORM 6

1. Provide a detailed description of the items or services that you have requested in each of the three grant types.

2. How are your requests related to the development of your program and your program's goals for the next year?

3. How do your requests help to meet the needs of your community?

4. Place a check beside the regional priorities that your requests will address.

Regional Priority 1: My grant request includes participation in approved Professional Development Opportunities. (include estimated cost of training in grant application)

Regional Priority 2: My grant request includes health and safety activities, materials and/or experiences (including but not limited to: cribs, high chairs, car seats, fire extinguishers, carbon monoxide detectors, etc. – see page 5 in application guide).

Regional Priority 3: My grant request includes School Readiness activities and/or experiences.

Explain how your requests relate to the regional priorities.

5. How do your requests support child care as it relates to creating high quality, culturally responsive and affordable care for families in Minnesota?

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CONTINUATION OF PROGRAM (NARRATIVE), FORM 7

This form should be completed if you are requesting funding for items or projects that will incur ongoing costs or the grant(s) will exceed 15 percent of your total annual budget.

Applicants must demonstrate a feasible continuation plan.

- 1. Describe your plan to continue and/or maintain the items requested for your program after this grant funding.**

-
- 2. How will your program sustain itself beyond the grant?**

-
- 3. What funding sources will be available to support your program?**

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REQUIREMENTS (SIGNATURE REQUIRED), FORM 8

Please read carefully and initial on the line beside each of the statements below. Sign and date the form at the bottom.

I understand that, if awarded a grant, our program must meet the following requirements:

_____ **Licensing:** Funding of start-up grants will be contingent upon our program becoming licensed, or offering care if legally exempt from licensing.

_____ **Two-Year Requirement:** If our program is awarded a grant we will be required to provide active child care services in Minnesota for a minimum of two years from the date of the award letter. If for any reason, our program ceases to provide active child care services within the required timeframe, we will be required to return purchased equipment and/or repay grant dollars on a prorated basis.

_____ **Training Requirement:** If our program receives a Child Care Services Grant, each of the staff included in our training plan will be required to complete 12 hours of training for grant awards up to \$500 or 16 hours of training for grant awards of more than \$500. The timeline for completing the training requirement will be outlined in the award letter if we receive this grant. I also understand that the training requirement must be completed prior to receiving any reimbursement.

_____ **Purpose:** Our program will use the grant funds for the intended purpose as stated in the grant award.

_____ **Reimbursement:** These grants are paid on a reimbursement basis. Any expenses incurred prior to the date of our award letter will not be reimbursed.

_____ **Services to Families Receiving CCAP:** Our program will not refuse services to families receiving assistance through the Child Care Assistance Program.

_____ **Completion of Surveys and Report Forms:** Our program will complete surveys, report forms, Provider Business Forms and level updates requested by our district CCR&R.

_____ **Language Access:** Our program will make our child care services available to families who are non-English speaking or speak English as their second language.

Authorized Signature

Title

Date

Center/Agency Name