Oneida Nation Childcare Services Program
American Rescue Plan Act (ARPA)
Stabilization Subgrants for Child Care Providers

Section 1. General Application Information

Child Care **Program/Center** Name (Legal Business/ License Name):	Location Address (City/State/Zip Code):	Mailing Address (if different):
Owner/Operator/Center Director Name:	Phone Number: Alternate Phone Number:	Contact Email:
Tribal and/or State Licensing or Other Identifying Number:	☐Licensed ☐ Certified ☐ Relative	Social Security or Taxpayer ID Number or DUNS Number:

Have you applied for or plan on applying for a State Child Care Stabilization Grant?☐ Yes ☐No

Section 2. Operational Status

What Type of program do you operate? Select all that apply
☐Family Child Care Home (licensed or certified) ☐ Licensed Child Care Center
☐ Emergency Relative Care Provider

Was your program licensed/registered/certified/regulated by 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:

Section 3. Child Count Information

What is the maximum licensed, identification, or approved capacity of your program?	Days of Operation: Hours of Operation:
What is your current average enrollment by age? Infant: Toddler: Preschool Age: School Age: **Total:**	**Of the children enrolled, how many receive funds from the following programs?** Tribal CCDF: State CCDF: Early Head Start: Head Start: State Prekindergarten: Other (please list): **Total:**
In January 2020, prior to COVID-19, what was your average enrollment by age: Infant: Toddler: Preschool Age: 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 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, Supplies, or Technology Needed in Response to COVID-19:	
Total:	

Additional Cost:		
Allowable Expenses	**Average Monthly Cost**	
Goods and Services to Maintain or Resume Services:	Amount:	Describe:
Mental Health Supports for Children or Staff:	Amount:	Describe:
Total:		
This is NOT the amount you will receive. The purpose is to calculate average monthly expenses.		

Section 5. Options for Fund Use

Subgrant funds may only be used for the following categories. Please check the box and enter the estimated monthly amounts per category. Because this is an estimate, you can move funds between categories without prior approval. You may choose to use funds for one or more of the following:

☐Personnel costs, benefits, premium pay, and recruitment and retention	Estimated Monthly Amount:
☐Rent or mortgage payments, utilities, facilities maintenance and improvements, or insurance	Estimated Monthly Amount:
☐PPE, cleaning and sanitation supplies and services, or training and professional development related to health and safety practices	Estimated Monthly Amount:
☐Purchases of or updated to equipment and supplies to respond to COVID-19	Estimated Monthly Amount:
☐Goods and services necessary to maintain or resume child care services (Describe here:)	Estimated Monthly Amount:
☐Mental health supports for children and employees (Describe here):	Estimated Monthly Amount:

☐Construction or major renovation of facility.* Describe needs in this area:	Estimated Monthly Amount:

*Indicating construction or major renovation needs does not guarantee funding will be available. In accordance with review and approval processes, any request for construction or renovation project funding must be approved through the Tribal Lead Agency by the Office of Child Care before funding can be spent.

Please indicate if you plan to use funds for expenditures prior to March 11, 2021. ☐Yes ☐No

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, C and D.

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 services), I must continue paying at least the same amount of weekly wages and maintain the same benefits (such as heath 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 and 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.

D. ☐ I will provide to the Oneida Nation Childcare Services Program a report with pictures after final money is spent, no later than December 29, 2023.

Provider Affirmation

The following signature affirms that I will adhere to the items noted I A, B, C and D. It also affirms I will only use the funds in the areas noted in section 5 of this application.

Provider Signature and Date: _____

_____ _____

Signature of Child Care Staff Verifying Complete Application Date

_____ _____

Signature of Child Care Staff Verifying Complete Application Date