Registered Family Child Care Provider

ECE COVID-19 Rapid Response Application

Provider Information

Applicant Information	
Provider's Name:	
Legal Entity Name (if different from above):	
Employer Identification Number -EIN (if you have one or Social Security Number):	
Date Established:	
Address:	
City:	
State:	
Zip Code:	
Email:	
Phone:	
Mailing Address (if different from above):	
City:	
State:	
Zip Code:	

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 March 2020, 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	Subsidy Program	Other
Infant				
Toddler				
Preschool				
School-Age				

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

Do you serve any special populations (please provide # of children falling into this category)?

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)	

Are you currently engaged in quality improvement activities (Grow NJ Kids or technical assistance)?

☐ Yes ☐ No

Do you currently participate in the Child and Adult Care Food Program (CACFP)?

☐ Yes ☐ No

Are you currently open or closed? Select One of the following:

☐ Open ☐ Voluntary Closure ☐ Open for Essential Workers

Staffing & Economic Impact

1. Do you have additional staff besides yourself (please include assistants and substitute)?
   ☐ Yes ☐ No ***(If no, skip to "Funding Needs)***
2. Do you currently have an employee sick leave policy in place and offer paid sick leave to your staff? ☐ Yes ☐ No

3. Provide information regarding your additional staff?

	# (full-time or part-time)
FCC Provider/Alternate (include yourself)	
Assistant	
Substitute	
Other	

4. 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 Family Child Care 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?
   [Check all that apply. Prioritize by listing in order of importance; 1 being most important]
   - Housing Support (Rent/mortgage) ☐
   - Utilities ☐
   - Paid sick leave for self or staff ☐
   - Paying for substitute ☐
   - 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 ☐
   - Reopening costs ☐
   - Marketing/communication of open/closed status ☐
   - Immediate need for professional development, training or consultation ☐
   - Other [please specify] ☐ _____

2. 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. How much are you requesting? $_____. What else should we know about this program, your organization, and the landscape in which you work? [250 words maximum. Use additional sheet if necessary]

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):

☐ 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)

What is your race/ethnicity? _____

What is your sex? _____

Is your gross annual household income at $59, 172 or below? ☐ Yes ☐ No

If yes, check the applicable box below:

☐ Under $20,000

☐ $20,001 - $29,999

☐ $30,000 - $39,999

☐ $40,000 - $49,999

☐ $50,000 -$59,172

Required Document Submissions:

- Current Certificate of Registration (PFP has on file)
- W9

Signature of Applicant:_____ Date: _____

Please submit completed application, along with W9 to FCC@programsforparents.org or send via Fax to 973-744-6809 by the July 24, 2020 deadline. Contact 973-744-4050 with questions.