**Southwest Human Development COVID-19 Fund for Early Care and Education Programs**

**Grant Guidelines**

Southwest Human Development, with support from the Vanguard Strong Start for Kids Program, has launched a COVID-19 Fund for Early Care and Education Programs to support the emergency needs of early childhood providers in Maricopa County, Arizona.

**Eligibility:** **Providers located Maricopa County who are also one of the following:**

* ADHS Licensed Child Care Center
* ADHS Licensed Home-Based Provider
* DES Regulated Family Child Care Home

**Highest priority will be given to programs that:**

* Single-site, individually owned and operated child care centers and home-based providers
* Demonstrate a commitment to high quality as evidenced by participation in First Things First programs, accreditation or other quality improvement initiatives.
* Primarily serve families with low incomes, children in the child welfare system (DCS)
* Accept Department of Economic Security child care subsidy
* Are at the highest risk of closing without outside support for a limited period

**Support Available**

Providers can request support to cover ongoing expenses, including: rent/mortgage assistance, payroll, utilities or other operating expenses. In order to apply for support, programs will need to demonstrate the revenue that has been or will be lost as a result of the COVID-19 pandemic. This is explained in further detail in the attached application.

**Maximum Request for funding is $5,000.**

**Application Process**

* Complete and sign the application form found on the following page.
* Submit completed application form and submit supporting documentation to [gward@swhd.org](mailto:gward@swhd.org).

**Southwest Human Development COVID-19 Fund for Early Care and Education Programs**

**Application Form**

***Organizational questions:***

|  |  |
| --- | --- |
| **Applicant Information** |  |
| Provider/Organization Name: |  |
| Legal Entity Name (if different from above): |  |
| Employer Identification Number-EIN (if you have one): |  |
| Date Established: |  |
| Address: |  |
| Address 2: |  |
| City: |  |
| State: |  |
| Zip Code: |  |
| **Primary Contact Information** |  |
| First Name: |  |
| Last Name: |  |
| Email: |  |
| Phone: |  |
| Address (if different from above): |  |
| Address 2: |  |
| City: |  |
| State: |  |
| Zip Code: |  |

***Application Questions:***

1. Legal entity type (For-profit/Non-profit) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Type of organization:   
    AZ Department of Health Services (ADHS) Licensed Child Care Center   
    ADHS Licensed Home-Based Provider

Department of Economic Security (DES) Certified Family Child Care Home

1. Please complete the table below for your site.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ADHS Licensed Capacity | DES Certified Capacity | Do you rent or own? | Quality First Star Rating | Accreditation |
|  |  |  |  |  |

1. What was your enrollment total on February 28, 2020?
2. What is your enrollment total as of the date you completed this application?
3. Do you serve any special populations (please provide # of children falling into this category in the table below)?

|  |  |
| --- | --- |
| **Special Populations** | **% of Children (or families) enrolled** |
| Children in the child welfare system (Department of Child Safety) |  |
| Low-income families (DES child care subsidy) |  |
| Children with disabilities |  |
| Other (please describe) |  |

1. In which quality improvement programs do you or your staff currently participate or have participated in within the past 6-month period? Please list name of program and organization that administers the program.

|  |
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|  |

1. What is your current operating status? (Select one.)

Open

Closed

1. What are your financial concerns? (Check all that apply.)

Facility Support (Rent/mortgage)

Utilities

Paid sick leave for self or staff

Making payroll

Lost income (replace co-pays, private pay, or other funding sources)

1. What is your current need for emergency funding?

|  |
| --- |
|  |

1. How will the requested be spent? Please complete the table below for each item you are requesting funding for.

|  |  |  |
| --- | --- | --- |
| **Budget Category** | **$ Amount Requested** | **Description of request (i.e. one month rent, pay for five staff for one month, etc.)** |
| Rent/mortgage |  |  |
| Personnel (Staffing) |  |  |
| Other (please list) |  |  |

1. (*Optional*) Describe measures already taken to meet this funding need.

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1. (*Optional*) What else should we know about your program, the families you serve and the situation you are in as a result of the COVID-19 pandemic?

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**If you are requesting funding for payroll, please also answer questions #14-16 below.**

1. Have you retained all staff?   
    Yes No Partial
2. Are you currently paying all retained staff?  
    Yes No Partial

If you selected partial, please provide additional explanation:

|  |
| --- |
|  |

1. How many staff do you currently employ at the site for which you are requesting funding (not including consultants/contractors, but if you earn a salary as an owner/director, include yourself)? Please enter your information in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Full-time on 2/1/20 | Full-time on 4/1/20 | Partial paid or furloughed staff on 4/1 |
| Directors/owners |  |  |  |
| Teaching staff |  |  |  |
| Support staff |  |  |  |
| Administrative staff/other |  |  |  |

***In addition to the completed application please provide the following documents:***

1. ADHS license # or DES certification #
2. Support for your budget request. If you are requesting funding for:
   * Lease/mortgage relief please provide a lease or mortgage statement reflecting address and monthly balance
   * Invoices for other operational expenses included in your application (e.g. utilities bill)

**Certifications and Signature Section**

By signing below, you certify to the following:

Applicant is in full 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 criterion):

* Holds current insurance coverage as required by local licensing/regulatory authority
* 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 commit to retain current staffing levels, to the best of your ability
* You intend to maintain business operations upon resolution of COVID-19
* You can meet the obligations set forth in the grant agreement

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Name of Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Please submit completed application and any relevant supporting documentation to** [**gward@swhd.org**](mailto:gward@swhd.org)