



**Cheyenne and Arapaho Tribal Child Care Program  
American Rescue Plan Act (ARPA)  
Stabilization Subgrants for Child Care Providers**

P.O. Box 450 North Lefthand Drive  
Concho OK, 73022

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If you have any questions or need help with completing this application, call the helpline at 405-422-7698 or 405-422-7694 or email at laceyg@cheyenneandarapaho-nsn.gov

**Section 1. General Application Information**

Child Care <b>Program/Center</b> 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:	<input type="checkbox"/> Licensed <input type="checkbox"/> License Exempt <input type="checkbox"/> Approved <input type="checkbox"/> Certified <input type="checkbox"/> Registered <input type="checkbox"/> Regulated	Social Security or Taxpayer ID Number or DUNS Number:
Owner/Provider Race: <input type="checkbox"/> American Indian or/Alaska Native Indigenous <input type="checkbox"/> Asian <input type="checkbox"/> Black or/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiracial	Owner/Provide Ethnicity: <input type="checkbox"/> Latino <input type="checkbox"/> Not Latino	Owner/Provider/ Center Director Gender:

Have you applied for or plan to apply for a State Child Care Stabilization Grant?  Yes  No

## Section 2. Operational Status

<p><b>What Type of program do you operate?</b> Select all that apply</p> <table><tr><td><input type="checkbox"/> Child Care Center</td><td><input type="checkbox"/> Family Child Care Group Home</td></tr><tr><td><input type="checkbox"/> Large Family Child Care Home</td><td><input type="checkbox"/> State Pre-kindergarten</td></tr><tr><td><input type="checkbox"/> School Age site</td><td><input type="checkbox"/> Head Start</td></tr><tr><td><input type="checkbox"/> Early Head Start</td><td><input type="checkbox"/> Faith based</td></tr><tr><td><input type="checkbox"/> Other</td><td></td></tr></table>	<input type="checkbox"/> Child Care Center	<input type="checkbox"/> Family Child Care Group Home	<input type="checkbox"/> Large Family Child Care Home	<input type="checkbox"/> State Pre-kindergarten	<input type="checkbox"/> School Age site	<input type="checkbox"/> Head Start	<input type="checkbox"/> Early Head Start	<input type="checkbox"/> Faith based	<input type="checkbox"/> Other	
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<input type="checkbox"/> Other										
<p><b>Was your program licensed/registered/certified/regulated by or before March 11, 2021?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>										
<p><b>What is the current status of your program?</b></p> <p><input type="checkbox"/> Open</p> <p><input type="checkbox"/> 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:</p>										
<p><b>Do you participate in the STARS quality rating system?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>										
<p><b>What is your current Star Level?</b></p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 1+</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> n/a</p>										
<p><b>Do you have subsidy Contract with DHS or Tribal CCDF?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> NO</p> <p>Specify State or Tribe: _____</p> <p>What percentage of children enrolled receive a subsidy? _____</p>										

### Section 3. Child Count Information

<b>What is the maximum licensed, identification, or approved capacity of your program?</b>	Days of Operation:  Hours of Operation:
<b>What is your current average enrollment by age?</b>  Infant:  Toddler:  Preschool Age:  School Age:  <b>Total:</b>	<b>Of the children enrolled, how many receive funds from the following programs?</b>  Tribal CCDF:  State CCDF:  Early Head Start:  Head Start:  State Prekindergarten:  Other (please list):  <b>Total:</b>
<b>In January 2020, prior to COVID-19, what was your average enrollment by age:</b>  Infant:  Toddler:  Preschool Age:  School Age:  <b>Total:</b>	
<b>Provider Statement: My estimated current monthly expenses are \$_____.</b>	

### Section 4. Current Average Monthly Operating Expenses

(See Attached Estimated Monthly Costs of Operations Budget Expense Tracking Tool)

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:	
<b>Total:</b>	

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

**Section 5. Options for Fund Use or (See attached Budget Expense Tracking Tool)**

Sub-grant 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:

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

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, and C.**

**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 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.
  
- 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 Cheyenne and Arapaho Child Care Program a monthly financial report by the 5<sup>th</sup> day of the following month, on how the awarded stabilization subgrant funds I received was spent. The financial report form will be reviewed and filed by the tribal lead agency to monitor compliance with applicable Federal & Tribal statutory and regulatory requirements.

### Provider Affirmation

**The following signature affirms that I will adhere to the items noted in 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