



**Turtle Mountain Band of Chippewa
Tribal Child Care Program
American Rescue Plan Act (ARPA)
Stabilization Subgrants for “Child Care Providers”**

P.O. Box 900
Belcourt, N.D. 58316

Phone: 701.477.2600 | Fax: 701.477.8259 | Email: <https://tmchippewa.com>

If you have any questions or need help with completing this application, call the helpline at
701.477.7238 or 701.477.7241 or email azure.janice@yahoo.com.

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:	<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 on applying for a State Child Care Stabilization Grant? Yes No

Section 2. Operational Status

<p>What Type of program do you operate? Select all that apply</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Family Child Care Home</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Child Care Center</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Family Child Care Group Home</td> <td style="border: none;"><input type="checkbox"/> State Prekindergarten</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Relative</td> <td style="border: none;"><input type="checkbox"/> Head Start</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> In-Home</td> <td style="border: none;"><input type="checkbox"/> Early Head Start</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Other</td> <td style="border: none;"><input type="checkbox"/> Faith based</td> </tr> </table>		<input type="checkbox"/> Family Child Care Home	<input type="checkbox"/> Child Care Center	<input type="checkbox"/> Family Child Care Group Home	<input type="checkbox"/> State Prekindergarten	<input type="checkbox"/> Relative	<input type="checkbox"/> Head Start	<input type="checkbox"/> In-Home	<input type="checkbox"/> Early Head Start	<input type="checkbox"/> Other	<input type="checkbox"/> Faith based
<input type="checkbox"/> Family Child Care Home	<input type="checkbox"/> Child Care Center										
<input type="checkbox"/> Family Child Care Group Home	<input type="checkbox"/> State Prekindergarten										
<input type="checkbox"/> Relative	<input type="checkbox"/> Head Start										
<input type="checkbox"/> In-Home	<input type="checkbox"/> Early Head Start										
<input type="checkbox"/> Other	<input type="checkbox"/> Faith based										
<p>Was your program licensed/registered/certified/regulated by or before March 11, 2021?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">OR</p> <p>Does your program meet Child Care and Development Fund health and safety requirements, including the completion of comprehensive background checks?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>											
<p>What is the current status of your program?</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>											

Section 3. Child Count Information

<p>What is the maximum licensed, identification, or approved capacity of your program?</p>	<p>Days of Operation:</p> <p>Hours of Operation:</p>
<p>What is your current average enrollment by age?</p> <p>Infant:</p> <p>Toddler:</p> <p>Preschool Age:</p> <p>School Age:</p> <p>Total:</p>	<p>Of the children enrolled, how many receive funds from the following programs?</p> <p>Tribal CCDF:</p> <p>State CCDF:</p> <p>Early Head Start:</p> <p>Head Start:</p> <p>State Prekindergarten:</p> <p>Other (please list):</p> <p>Total:</p>

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 (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:	
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 or (See attached Budget Expense Tracking Tool)

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:

<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:
<input type="checkbox"/> 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, 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 TMBCI Child Care Program a monthly financial report by the 5th day of the following month, on how the awarded stabilization subgrants 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 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