

Quality Counts Child Care Grant 2009-2010 Application

Funded by the Illinois Department of Human Services, Bureau of Child Care & Development

CCRRN
207 W. Jefferson St., Ste 301
Bloomington, IL 61701

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- ▶ Please type or print using black or blue ink. The original application and budget forms **must** be used.
- ▶ Please refer to the Quality Counts Child Care Grant Guidelines & Requirements for assistance in completing this application.

I am a first time applicant. Yes No

I am applying for: Category 1 Funding
 Category 2 Funding (See Guidelines & Requirements Section 1 #1 6 #6)

CONTACT INFORMATION:

Program/FCC Name: _____ (Licensed - name as it appears on license)

Contact Person Name: _____

Mailing Address: _____

City: _____ County: _____ State: _____ ZIP Code: _____

Program Location: _____

City: _____ County: _____ State: _____ ZIP Code: _____

Phone: () _____ H W C Alternate Phone: () _____ H W C

Fax: () _____ E-mail: _____

Program is: For-Profit Not-for-Profit Social Security or Federal ID Number: _____

PROPOSAL INFORMATION

(See Guidelines & Requirements Section 2 #9)

Priorities You May Be Addressing in Your Proposal: (Check any and all that apply)

<input type="checkbox"/> Increasing capacity for infants/toddlers/twos.	<input type="checkbox"/> Improving the quality of care for infants/toddlers/twos.
<input type="checkbox"/> Increasing capacity for school-aged children (Full-year or school year only).	<input type="checkbox"/> Improving the quality of care for school-aged children (Full-year or school year only).
<input type="checkbox"/> Creating the ability to accommodate children and families with special needs*.	<input type="checkbox"/> Maintaining the ability to accommodate children and families with special needs*.
<input type="checkbox"/> No priority addressed	

* A child with special needs is a child who has been diagnosed by a professional and receives special services from the public school, a community agency or regular care by a physician for a medial condition.

Amount & Purpose of Funds Requested:

(See Guidelines & Requirements Section 3 #13 & #14 and Section 6 #22 - #26)
 ♦Please transfer dollar amount totals from the ITEMIZED BUDGET FORM AFTER completing your budget.♦

Amount of funds which will affect:

Equipment/Materials for Children

Infant	\$ _____
Toddlers	\$ _____
2 Year Olds	\$ _____
Preschool	\$ _____
School Age	\$ _____
All Ages (3 or more age groups)	\$ _____
Special Needs	\$ _____

Facility Improvement

Infant/Toddlers/Twos Only	\$ _____
All Ages	\$ _____

Professional Resources \$ _____

Family Resources \$ _____

Did you or a person from your agency attend the Bidders' Conference?

(See Guidelines & Requirements Section 2 #10 & #11)
 Yes No Date Attended: ____/____/____
 Name of person who attended: _____

Did you receive a Quality Counts Grant last year? Yes No

(See Guidelines & Requirements Section 2 #10 and Section 6 #21)

Are there any other funds to support your request?

Yes No If yes, amount of funds? \$ _____

Are the items you are requesting required by:

(See Guidelines & Requirements Section 4 #19)

IDCFS Licensing? Yes No

If yes, please attach a:

- Copy of corrective action plan or IDCFS letter, *and/or*
- List of licensing standards you are addressing *only if* transitioning from License-Exempt to Licensed, or have a change in license status and have written timeline/plan in place.

Fire Marshall? Yes No

If yes, please attach a copy of the document from the Fire Marshall.

Health Department? Yes No

If yes, please attach a copy of the document from the Health Department.

Total Amount: _____

This amount must equal the breakdown above and the total on your Itemized Budget Form.

PROGRAM INFORMATION

Licensed Program ó License ID # _____ License-Exempt Program

Program Type (Check only one):
 Family Child Care Home Group Family Child Care Child Care Center Head Start ISBE Preschool For All

(See Guidelines & Requirements Section 1 #1 - #6)
 1. Is your program accredited? No Yes (If yes, from which organization): NAFCC NAEYC NEPA NAC/NACCP COA
 2. Does your program meet the QC Grant requirements for Accreditation Self-Study?
 No Yes (If yes, from which organization): NAFCC NAEYC NEPA NAC/NACCP COA
 3. Is your program a Quality Counts - Quality Rating System (QRS) program? No Yes
 If yes, at what Star Level (licensed providers): 1 2 3 4 or If yes, at what Training Tier (license-exempt FCC): 1 2 3

Is your program listed on the *CCRRN Referral* provider database? Yes No
 (If no, you must call 1.800.437.8256 prior to submitting this application in order to be eligible for funding.)

Number of years you have been providing legal child care in your current (physical) location:
 Less than 1 year 1-2 years 3-5 years 6-9 years 10-14 years 15 or more years

You enroll children: Full-time Part-time Both

Days you provide child care: Monday through Friday OR Only open the following days:
 Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Hours: Full Day (8 or more consecutive hours providing care) Open: _____ AM to _____ PM

Your overall program is: Full-Year (at least 49 weeks per year caring for children) School-Year

Do you provide school-age care? Yes No (If yes, check the one that best applies to your program)
 Before and/or After School (49 weeks including school holidays, closing and breaks) Before and/or After School - School Year Only (180 days/9 months)
 Summer (3 months minimum of 8 hours per day) School Holidays
 Closing and Breaks Only

If you are a family child care provider, do you own your home? Yes No

If you are a child care center, do you own or rent the facility? Own Rent

CAPACITY/ENROLLMENT

Information by Age Group

Capacity Definition: For licensed centers and homes, this is the capacity listed on your IDCFS license. For license-exempt centers and homes, this is the number of children that could be cared for by your program at any one time.

Enrollment Note: Number of Children Enrolled can exceed the number of children at any one time due to part-time children and/or shift care.

Family Child Care¹: For family child care, please include your own children under age 13, in total enrollment.

Changes in Capacity²: Any changes in capacity MUST be supported in your grant narrative and must fall into one of the following categories:
 ♦ License exempt center or home becoming licensed
 ♦ Licensed Home becoming a Licensed Group Home
 ♦ Adding or increasing capacity for: Infant/Toddler/Twos and/or School-Age Child Care and/or Preschool

Age Category	Center Capacity	Family Child Care Capacity	Family Child Care/Center Programs: Number of Children Currently Enrolled ¹	Family Child Care/Center Programs: Number of Children with Special Needs Currently Being Served	If applicable, Capacity Increases (Number of Spaces Grant Is Expanding) ²
Infants (6 weeks to 14 months)					
Toddlers (15 months to 23 months)					
2 Year Olds (24 Months to 35 months)					
Preschool (36 months to 59 months)					
School-age (60 months to 12 years)					
TOTAL					

Do you provide care for other types of schedules? Please provide detail.
 Evening (6 PM – 10 PM) Total Capacity: _____ Total Enrollment: _____
 Night (10 PM – 6 AM) Total Capacity: _____ Total Enrollment: _____
 Weekend Total Capacity: _____ Total Enrollment: _____

Comments: (optional)

All applicants should use this checklist in order to submit a complete grant proposal.

- I used the 2009-2010 application and budget forms as required.
- I completed all areas of the application. If a question was not applicable I inserted N/A.
- I checked the numbers on my budget form for accuracy.
- If I am requesting monies for contracted work, **I have attached at least two itemized bid estimates for work and materials. All contract labor work must be licensed and bonded.** The preferred bid is included in my budget form.
- If I have included pictures I have attached them to all copies.
- If my program is currently Accredited, I attached a copy of my certificate of accreditation.
- If my program is currently enrolled in Accreditation Self-Study, I attached a copy of all required documentation.
- If my program is currently QRS rated, I attached a copy of my QRS certificate.
- If my program is currently a Head Start program, I attached the Grantee Certificate or Letter of Compliance.
- If I am applying for Category 2 Funding, I have completed an assessment(s). I have attached the appropriate Assessment Profile Sheet(s).
 - FCCERS-R ITERS-R ECERS-R SACERS PAS BAS
 - License-Exempt Family Checklist QRS/National Louis Summary Report (first page only) and/or Facility Report
- I enclosed the original copy plus three (3) additional copies of all materials in order:
 - (1) Application
 - (2) Budget Form
 - (3) Grant Narrative
 - (4) Supporting documentsI have also made a copy for my own records and understand my proposal will not be returned.
- If applicable, I attached copies of the following documentation *to all 4 sets*:
 - Fire Marshall document and/or IDCFS corrective action plan and/or
 - Health Department document and/or List of licensing standards you are addressing **only if** transitioning from License-Exempt to Licensed, or have a change in license status and have written timeline/plan in place.
- I signed and dated my application.

Return all required documents by March 19th, 2010 no later than 4:00 p.m. to:

**Contact Person: Jill McNiff
CCRRN
207 W. Jefferson St., Ste 301
Bloomington, IL 61701**