Kenaitze Indian Tribe
American Rescue Plan Act
Stabilization Grants for Child Care Providers, Infant Care

P.O. Box 988 Kenai, AK 99611
Phone: 907.335.7616

If you have questions, or need help in completing this application, call the helpline at (907)335-7616 or email heschaefer@kenaitze.org

Section 1. General Applicant Information

<table>
<tr><td rowspan="2">Child Care Program Name:</td><td>Location Address:</td><td rowspan="2">Mailing Address:</td></tr>
<tr><td>Location Zip Code:</td></tr>
<tr><td>State or Territory Licensing or Other Identifying Number:</td><td>License Status</td><td>DUNS Number or Taxpayer ID Number:</td></tr>
<tr><td>Legal Business Name or DBA:</td><td colspan="2">Operator/Director Name:</td></tr>
<tr><td>Operator/Director Contact email:</td><td>Phone Number:</td><td></td></tr>
<tr><td colspan="2">Operator/Director Race:</td><td>Operator/Director Ethnicity:</td><td>Operator/Director Gender:</td></tr>
</table>

Section 2. Operational Status

What type of program do you operate?
Was your program licensed/registered/certified/regulated on or before March 11, 2021? **<u>OR</u>** **Does your program meet Child Care and Development Fund health and safety requirements including the completion of comprehensive background checks?**

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What is the current status of your program? 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:

Section 3. Child Count Information

What is the licensed or identified capacity of your program?	**Days of Operation:** **Hours of Operation:**
What is your current enrollment by age: Infant: Toddler: Preschool: School Age: **Total:**	**Of the children enrolled, how many are funded by the following programs?** State Prekindergarten: Tribal CCDF: State CCDF: Other: **Total:**
What is your current enrollment capacity by age: Infant: Toddler: Preschool: School Age: **Total:**	

Provider Statement: My estimated current monthly expenses are: $_______________

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Section Four: Current Average Monthly Operating Expenses

<table>
<tr><td>Allowable Expenses</td><td colspan="2">Average Monthly Cost</td></tr>
<tr><td>Payroll: # of full-time employees ____, # of part-time employees ____</td><td colspan="2"></td></tr>
<tr><td>Benefits:</td><td colspan="2"></td></tr>
<tr><td>Other Personnel Costs:</td><td colspan="2"></td></tr>
<tr><td>Rent or Mortgage:</td><td colspan="2"></td></tr>
<tr><td>Facility Expenses (Utilities, Insurance, Maintenance):</td><td colspan="2"></td></tr>
<tr><td>Personal Protective Equipment (PPE), Including Cleaning and Sanitation Supplies and Services:</td><td colspan="2"></td></tr>
<tr><td>Training Expenses for Staff on Health and Safety Practices:</td><td colspan="2"></td></tr>
<tr><td>Equipment and Supplies in Response to COVID-19:</td><td colspan="2"></td></tr>
<tr><td>Total:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Additional Costs:</td></tr>
<tr><td>Goods and Services to Maintain or Resume Services:</td><td>Amount:</td><td>Describe:</td></tr>
<tr><td>Mental Health Supports for Children or Staff:</td><td>Amount:</td><td>Describe:</td></tr>
<tr><td>Total:</td><td colspan="2"></td></tr>
<tr><td colspan="3">This is NOT the amount you will receive. The purpose is to calculate average monthly expenses.</td></tr>
</table>

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Section 5. Options for Use of Funds

Subgrant funds may only be used for the following categories. Please enter the estimated monthly per category. Estimated monthly amounts will be taken into consideration for grant award amounts.

Infant Supply Building

◯ Goods and services necessary to maintain or resume infant child care services. Describe:	Estimated Monthly Amount:
◯ Personnel costs related to recruitment and retention for infant care staff	Estimated Monthly Amount:

Certification

To receive a stabilization grant, I agree to use the funds only for the categories and purposes indicated on this application.

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 to my knowledge, the information included is accurate. I am also 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 service), 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 co-payments 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.

Provider Affirmation

The following signature affirms that I will adhere to the items noted in A, B, and C. It also affirms I will only use the funds in the areas noted in section 5 of this application.

Provider Signature and Date: