

PROFESSIONAL DEVELOPMENT / PROGRAM IMPROVEMENT FUND

APPLICATION (July 2009 – June 2010)



4-C: Community Coordinated Child Care

I am applying for: Program Accreditation/Credential Funds
 Funds for Training/Workshop/Conference/Off-Site Training/Assessment Tools

Please refer to Professional Development/Program Improvement Funds Guidelines & Requirements for assistance in completing this application.
 Type or print using black ink.

STEP 1: Personal Information (home contact information)

Applicant First Name: _____ Applicant Last Name: _____
 Applicant Street Address: _____
 City: _____ State: _____ Zip Code: _____
 County: _____ Phone Number: () _____
 Email (optional): _____

Role: Center Director Center Teacher Center Assistant Teacher Family Child Care Owner Family Child Care Staff Other _____

What age group do YOU currently provide care for? (Center staff check one primary age range; FCC providers check all that apply).

Infants (6 wks. – 14 mos.) Toddlers (15 - 23 mos.) Twos (24 - 35 mos.) Pre School (3 - 5 yrs.) School Age (K – 12 yrs.) None (for program staff who do not directly work with children)

STEP 2: Program Information (complete the following for your current place of employment or family child care business)

Name of Business: (if applying on behalf of an association, use association name – if licensed, use the name as it appears on your license): _____

Business Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 County: _____
 Phone Number: () _____ Fax Number: () _____

What date did you begin employment at this site? Month: _____ Date: _____ Year: _____

Address Preference: Use personal address Use program address

Email Address: _____ Personal Program

Program Type: Center Family Child Care Group Family Child Care
 Head Start Preschool for All Association (**skip to Step 3**)

Status: License-Exempt Licensed _____ DCFS License Number _____ What is the total **current** enrollment in your program? _____

Infants (6 wks. – 14 mos.) Toddlers (15 - 23 mos.) Twos (24 - 35 mos.) Pre School (3 - 5 yrs.) School Age (K – 12 yrs.) None (for program staff who do not directly work with children)

Does the program you work for currently care for children whose care is paid for by the IDHS Child Care Assistance Program (subsidy)?

Yes No

If yes, please have the *program director* complete the following formula to determine the percentage of children in your program receiving IDHS child care financial assistance.

To calculate: Total Number of children with IDHS Financial Assistance **DIVIDED** by Current Total Enrollment
MULTIPLIED by 100 **EQUALS** Percentage of Children Receiving IDHS Assistance.
 (FCC providers: include your own children, under age 13, in enrollment)

$$\frac{\text{\# of IDHS Children}}{\text{Current Total Enrollment}} \times 100 = \text{\% Percentage of IDHS Children}$$


STEP 3: Funding Request Information (Select ALL that you are requesting funding for)

You **CANNOT** have more than one request per application.

I am requesting Professional Development/Program Improvement Funds to: **check (X) all that apply within your requested category**

REASON	TUITION	CREDENTIALING PROGRAM	WORKSHOP/ CONFERENCE/ OFF-SITE TRAINING	ACCREDITATION	ASSESSMENT TOOLS	ON-SITE IN-SERVICE/ GROUP TRAINER FEE
Implement better practices						
Meet DCFS training requirements						
Obtain qualifications for a new position						
To obtain a credential (new or renewal).						
Earn college coursework credit						
Increase my level to receive a Great START bonus						
Meet accreditation standards						
Assess a program						
Other						

INDIVIDUAL OPTIONS: Individuals may apply for a maximum of \$1000 per fiscal year. (Maximum amounts that can be requested: Tuition \$500- limit 1 class per semester, Books \$150). Partial funding may be awarded.

(Refer to Guidelines & Requirements, Page 1, #2, #3A)

A. TUITION (Refer to Guidelines & Requirements, Pages 1&2, #3A)

Name of college or university: _____

Name of course: _____ Course number: _____

Course start date: _____ Course end date: _____

New student at this institution Returning student at this institution

Number of credits you expect to receive/received for this course? _____ Type of hours: Semester Hours Quarter Hours
 Type of credit: Undergraduate Graduate

Total Amount(s) Requested	\$	Max
<input type="checkbox"/> Tuition		\$500
<input type="checkbox"/> Required Books/Software		\$150

B. CREDENTIALING PROGRAM (Please check category below) (Refer to Guidelines & Requirements, Page 2 B)

Total Amount(s) Requested	\$	Max
<input type="checkbox"/> Child Development Associate (CDA) Assessment Fee		\$325
<input type="checkbox"/> Child Development Associate (CDA) Second Setting		\$225
<input type="checkbox"/> Illinois Director Credential (IDC)		
<input type="checkbox"/> Gateways ECE Credential (circle level) 2 3 4 5		
<input type="checkbox"/> Gateways Infant / Toddler Credential (circle level) 2 3 4 5		
<input type="checkbox"/> Application Fee		\$75
<input type="checkbox"/> Transcript Evaluation/Review Fee		\$350
<input type="checkbox"/> Portfolio Assessment/Evaluation Fee		\$150
<input type="checkbox"/> Level Advancement Fee		\$75
<input type="checkbox"/> Certified Childcare Professional (CCP) Assessment Fee		\$495
<input type="checkbox"/> Credential Renewal Fee		\$75
<input type="checkbox"/> Credentialing Information Packet		\$23
<input type="checkbox"/> Credential Advisor (Max. of 5 hours) (Max. \$50 per hour) (documentation needed from your advisor for hours spent providing services)		\$250
<input type="checkbox"/> CARE Courses		\$400

- If applying for a CDA, how many CDA content hours have you earned? _____
- If applying for a CDA Advisor please list his/her name _____
- Indicate the highest degree earned by your CDA Advisor: CDA Associates Bachelors Masters PhD

C. WORKSHOP/CONFERENCE/OFF-SITE TRAINING (Refer to Guidelines & Requirements, Page 2, C)

(Attach conference announcement and/or outline and description of conference). (Fees will only be funded at the early bird rate).

Name of event: _____ Date(s) attending: _____

Location: _____ City: _____ State: _____

Number of training hours you expect to receive/received: _____

Type of credit: (Check all that apply): DCFS Clock Hours CEUs (Continuing Education Units) CDA Clock Hours (Child Development Associate) CPDUs (Continuing Professional Development Units) Other _____

Workshop/Conference/Off-Site Training (cont.)

Total Amount(s) Requested	\$	Max
<input type="checkbox"/> Workshop/Conference/Off-Site Training Registration Fee		Min \$75-Max \$400
<input type="checkbox"/> Lodging (3 night maximum)		\$100 per night

PROGRAM / AGENCY OPTIONS: (Refer to Guidelines & Requirements, Page 1, #2)

D. ACCREDITATION (Please check category below) (Refer to Guidelines & Requirements, Page 2, D)

Total Amount(s) Requested	\$	Max
<input type="checkbox"/> NAFCC Self Study Step 1		\$300
<input type="checkbox"/> NAFCC Application Step 2		\$500
<input type="checkbox"/> NAFCC Re-Accreditation Step		\$500
<input type="checkbox"/> NAEYC Step 1: Enrolling in self study (Program Capacity _____)		\$775
<input type="checkbox"/> NAEYC Step 2: Becoming an applicant (Program Capacity _____)		\$425
<input type="checkbox"/> NAEYC Step 3: Becoming a candidate (Program Capacity _____)		\$1150
<input type="checkbox"/> NECPA Application Fee (Program Capacity _____)		\$500
<input type="checkbox"/> NECPA Verification Fee (Program Capacity _____)		\$1350
<input type="checkbox"/> COA Application Fee		\$250
<input type="checkbox"/> COA Accreditation Fee		\$2400
<input type="checkbox"/> COA Site Visit Fee		\$1800
<input type="checkbox"/> NAC Application Fee (Program Capacity _____)		\$350
<input type="checkbox"/> NAC Validation Fee (Program Capacity _____)		\$1400
<input type="checkbox"/> Accreditation Mini-Grant (equipment & materials) (Itemized list required)		\$500
<input type="checkbox"/> Accreditation Advisor (Max. of 5 hours) (Max. \$50 per hour) (documentation needed from your advisor for hours spent providing services)		\$250
<input type="checkbox"/> Accreditation Annual Report Fee		\$450

E. ASSESSMENT TOOLS (Refer to Guidelines & Requirements, Page 3, E) Agencies/Programs may apply for funding to be used toward assessment tools, ERS resource materials (itemized list required) and/or advisor including:

Total Amount(s) Requested	\$	Max
<input type="checkbox"/> Family Child Care Environment Rating Scale – Revised (FCCERS-R)		\$26
<input type="checkbox"/> Infant/Toddler Environment Rating Scale (ITERS-R)		\$26
<input type="checkbox"/> Early Childhood Environment Rating Scale (ECERS-R)		\$26
<input type="checkbox"/> School Age Care Environment Rating Scale (SACERS)		\$26
<input type="checkbox"/> Program Administration Scale (PAS)		\$26
<input type="checkbox"/> Business Administration Scale (BAS)		\$26
<input type="checkbox"/> ERS Resource materials (e.g., books, VHS/DVD)		\$65
<input type="checkbox"/> Assessment Advisor (Max. of 5 hours) (Max. \$50 per hour) (documentation needed from your advisor for hours spent providing services)		\$250

GROUP OPTIONS: (Maximum amount allowed for group training: \$450)

F. ON-SITE IN-SERVICE/GROUP TRAINER FEE – attach brochure and/or outline and description of training
(Refer to Guidelines & Requirements, Page 3, F)

On-Site In-Service/Group Trainer Name: _____ Date of Event: _____

Topic Title: _____ Number of Training Hours: _____

Location: _____ City: _____ State: _____

Estimated number of participants: _____ Audience: (check all that apply) Staff Membership

Type of credit: (Check all that apply)

- DCFS Clock Hours CEUs (Continuing Education Units) CDA Clock Hours (Child Development Associate)
 CPDUs (Continuing Professional Development Units) Other _____

Total Amount Requested	\$	Max
<input type="checkbox"/> On-Site In-Service/Group Trainer Fee		\$450

****Application submission does not guarantee that funds will be awarded****

STEP 4: Payment Information (refer to Guidelines & Requirements, Page 4, #4)

Total Amount Requested: \$ _____ (check (x) one)

- Tuition Workshop/Conference/Off-Site Training On Site/In-Service/Group Trainer Fee
 Accreditation Credentialing Program Assessment

Name Made Payable To: _____

Address _____ City: _____ State: _____ Zip Code: _____

Payee Social Security Number/Student ID or FEIN Number (REQUIRED): _____ Phone Number: _____

STEP 5: Narrative Requirements

All applicants/programs must respond in their own words to the following questions. If you answer yes to question two (2), please attach list of additional funding resources and explain how those funds support this activity. Your response may be printed or typed.

- 1) If only partial funds are available, will you complete the activity? Yes No
- 2) Are you receiving additional funds from any other source to support this activity? Yes No (if yes, check all that apply)
 Gateways Scholarship United Way employer match SAM Program
 MAP PELL Other (please specify) _____
- 3) For **credential and accreditation funds**, please attach a written timeline that describes how you will reach your goal of credential and/or accreditation.
- 4) If you are requesting an **accreditation mini-grant**, please attach an itemized budget and explain how these items are relevant to the accreditation criteria.

STEP 6: Application Checklist and Authorization

- I completed all areas of the current application. If a question was not applicable I inserted N/A.
- I signed and dated my application.
- The payment information I have submitted is correct.
- I completed and attached my narrative responses.
- I have included a copy of all receipts and certificate of completion (if applicable).

I have completed all documentation that was requested in the guidelines. I certify that the above information is true and accurate, that I have not been indicated of child abuse and neglect and that my name or the names of my center employees (if applicable) are not listed on the child abuse tracking system. Further, I grant permission for a representative of the Illinois Department of Children and Family Services or their agent to release information about my pending or current Day Care Home, Day Care Group Home or Day Care Center license if applicable to my application.

Applicant Signature Date

Director/Administrator Signature Date

Pre-payment cannot be made until a complete application is received and/or Payment for reimbursement cannot be made until all required documents are received.

Applications are due by: Friday, November 13, 2009

Return application and all required documents to:

<p>Carroll, DeKalb, Lee, Ogle, Whiteside Counties Kim Sciacero 155 N. Third St., Suite 300 DeKalb, IL 60115 (815) 758-8149 ext. 226</p>	<p>McHenry County Katrina Gofron-Ellison 667 Ridgeview Drive McHenry, IL 60050 (815) 344-5510 ext. 16</p>
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