Children's Trust of Alachua County:
2020 ELCAC Pandemic Learning Pods Funding Application

Early Learning/Child Care Provider

Please print and fill out completely.

1. Provider Information

Legal Name of Provider and d/b/a Name:_____

_____

P.O. Box/Mailing Address: _____

City/State/Zip:_____, FL_____County_____

Phone #1_____License #_____Licensed Ages to serve: _____

Provider email address_____Contact Person_____

Provider Type (check all that apply): ☐Child Care Facility ☐Family Child Care Home ☐ Large Family Child Care Home

2. Eligibility Criteria for each Early Learning/Child Care Provider

☐ Yes ☐ No Do you have a current School Readiness Contract?
☐ Yes ☐ No Is there access for School-Age Children to use internet or Wi-Fi services?
☐ Yes ☐ No Are there computers available for School-Age children to use if a device is not provided by Alachua County Public Schools?
☐ Yes ☐ No Is there space available to properly social distance School-Age children 6 feet apart and keep a 1:10 staffing ratio?
☐ Yes ☐ No Is the site/center able to provide meals and snacks to the School-Age through an approved Food Program?

If all responses are yes, provider is eligible to participate in the 2020 ELCAC Pandemic Learning Pods program, funded through the Children's Trust of Alachua County

Early Learning/Child Care Provider Attestations

I am submitting this application to qualify for and potentially receive funding from the Children's Trust of Alachua County for serving selected School-Age children participating in the 2020 ELCAC Pandemic Learning Pods Program. I also understand and agree to adhere to the" Guidance for "Child Care Programs that Remain Open" set forth by the CDC, require all staff and children wear masks, and ensure that all staff are Level II background screened. I attest to the fact that the information I have provided in this application is true and accurate and understand if my application does not meet the requirements, I will not be eligible to participate in the program. I have read over this application to ensure completeness and correctness and have made a copy of this application for my own records.

Signature of Authorized Provider Representative

Name_____

Date_____

Contact Phone _____

I confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

Sections below – for ELCAC use only

3. Application Information Provided to/Processed by – completed by ELC staff

☐ Yes ☐ No Is this application form complete?

☐ Yes ☐ No Does the sponsoring provider meet the listed eligibility criteria?

If all above responses are yes, this application form can be accepted.

Name: Rachel Eubanks

Date: _____ Contact Phone: 352-375-4110, ext. 123

Email: reubanks@elcalachua.org