



Awareness & Training
For quality childcare

General Instructions for Continuing Education Grant Application

All applications for grants must be completed on the official application form and must be faxed, mailed, scanned/emailed or hand-delivered to:

Physical & Mailing Address:
Department of Workforce Services
WY Quality Counts
5221 Yellowstone Road
Cheyenne, WY 82009

Applications may be faxed to 1-866-373-6061.

Applications will be accepted if faxed, postmarked, scanned/emailed or hand delivered:

- No more than one hundred ten (110) days before the scheduled training start date, and
- No less than forty-five (45) days before the scheduled training start date.

Funding Limits.

If the application is approved, the grant applicant will be eligible for a funding limit of no more than one thousand dollars (\$1,000.00) per participant, per state fiscal year (July 1 through June 30). The child care facility shall not substitute funds normally provided for training or funds obtained from another source with Continuing Education Grant Funds.

Assistance is available by contacting the DWS Administrative Office in Cheyenne at (307) 777-2439 or E-mail to: wygcc@wyo.gov

Please see our website at www.wyqualitycounts.org for WY Quality Counts! Educational Development Program rules, as well as detailed information and application procedures/rules for WY Quality Counts! Continuing Education Grants.

Child Care Business Information

1. Child Care Business Name — The official name used for tax reporting and contracts.
2. Business FEIN or Business Registered SSN — The Federal Employer Identification Number (FEIN) or registered SSN of the child care business as used on tax forms, unless the business is a sole proprietor or legally exempt.
3. Street Address — Physical location of the child care business.
4. Mailing Address — If different from the street address.

5. City — City in which the child care business is located.
6. State — State in which the child care business is located.
7. Zip — Zip code of the address where the child care business is located.
8. Faith-Based Child Care Business — Please mark “yes” or “no”. (For contract purpose only.)
9. Primary Contact — The first and last name, title, e-mail, telephone and fax number of the child care business contact.
10. Secondary Contact: If different from the primary contact, the first and last name, title, e-mail, telephone and fax number.
11. Name of individual who is authorized to sign the contract for the business — The full name of the individual who is accepting legal and fiscal responsibility for the grant on behalf of the business. The person named in this block must personally sign the contract documents. Please include their title, telephone number and e-mail address.
12. Indicate whether you are or may receive funds from another source for this training.
13. If answering “yes” to line 12, state the source and amount of funding you will be receiving.
14. Total Estimated Expense — From line 32.
15. Business Match — From line 33.
16. Total Amount Requested — From line 34.
17. Estimated Amount per Employee — From line 35.

Continuing Education Information

18. Training Start Date — The first day of actual training/coursework.
19. Training End Date — The last day of actual training/coursework.
20. Training City — The city the applied for training will be held.
21. Training State — The state the applied for training will be held.
22. Training Provider — The legal name of the individual or entity providing the training.
23. Training Title — The name of the training event and provide a brochure or other documentation from the training provider.
24. Indicate whether this training is required CORE training by the child care business to be licensed. (CORE training is: Fire Safety, Child Abuse, Sanitation, Blood Borne Pathogens, First Aid, CPR, etc.)
25. Indicate whether this training will upgrade a participant’s current skill level.
26. Indicate whether the training is for STARS credit.
27. Indicate whether the training can be completed in six calendar weeks.
28. Check the competencies, if any, that the training applies.

Continuing Education Budget

29. Registration, tuition, class fees and materials for all participants attending the training event. (Receipt needed after training.)
30. Participant Travel Expense — Funding of participant travel expenses will be allowed only if the training occurs in a location other than the city where the business is located.
 - a. Airfare — May be an estimated amount. For airfare over \$500.00, verification of cost is required.
 - b. Mileage — Will be funded at the current state mileage rate found on the Wyoming State Auditor's website, for the use of personal vehicles. Include the total number of miles to be traveled. Use www.mapquest.com to calculate mileage from city to city.
 - c. Meals & Incidental Expenses (M&IE) — Funding will be based on the current State M&IE rates which can be found at <https://www.gsa.gov/travel/plan-book/per-diem-rates>.
 - d. Lodging — Will be funded based on the actual rate. Charges for telephone calls, movies and other amenities are not eligible for funding
 - e. Other Travel Expenses — Please provide an explanation for expenses not included above.
31. Fees for Continuing Education Units/Certifications — List any fees for continuing education units not already listed in any of the above fields. (Receipt will need to be provided after training.)
32. Total Estimated Expenses — The sum of lines 29 through 31.
33. Less Business Match — The mandatory minimum employer contribution is 10% of allowable expenses. This is the portion of the Total Estimated Expenses for which the business is responsible. To find this amount, multiply line 32 by 0.10.
34. Total Grant Amount Requested — The total estimated expenses, minus the business match. To find this amount, subtract line 33 from line 32.
35. Estimate Grant Amount per Employee — The amount of funding requested for each employee. To find this amount, divide line 34 by the number of participants.

Unallowable Expenses:

- Trainee wages or fringe benefits;
- Administration Costs;
- Travel expenses when the training is held in the employer's town or city; and
- Cost of preparing the grant application.

Participant Information

36. First Name — The official first name of the participant used for tax reporting and contracts.
37. Last Name — The official last name of the participant used for tax reporting and contracts.
38. SSN — The participant's full social security number.
39. STARS ID # - The participant's STARS ID number.
40. Current Rate of Pay — The participant's current rate of pay (hourly or monthly) before the training event, before deductions, as of today's date.
41. Est. Rate of Pay after Training — The participant's estimated rate of pay (hourly or monthly) after the training event, before deductions.

42. Average Number of Hours Worked Weekly — The average number of hours per week the participant works for the child care business.

Checklist

Please check the boxes in the checklist to ensure that the application is complete. **Please note that incomplete applications could be denied.**

Signatures

The application must be signed by an authorized representative of the requesting child care provider. Also enter your current slot and enrollment counts.

Failure to sign will result in rejection of the application.

The completed application, with any supporting documentation or letters, must be faxed, mailed, scanned/emailed or hand-delivered to the address on the application form. **Please only send in your application, keeping instructions for future reference.** Applications may be faxed to 1-866-373-6061.

Thank you for your application



Application for Continuing Education Grant

Child Care Business Information

¹Child Care Business Name:

²Business FEIN or Business Registered SSN:

³Street Address:

⁴Mailing Address:

⁵City:

⁶State:

⁷Zip:

⁸Faith-Based Child Care Business: (Contract purposed only) Yes No

⁹Primary Contact:

Mr. Ms. Dr. Last Name, First Name

Title:

Telephone:

Fax:

E-Mail:

¹⁰ Secondary Contact:

Mr. Ms. Dr. Last Name, First Name

Title:

Telephone:

Fax:

E-Mail:

¹¹Name of the individual who is authorized to sign the Contract for the business:

Mr. Ms. Dr. Last Name, First Name

Title:

Telephone:

E-Mail:

¹²Are you receiving or plan to receive funding for this program from any another source? Yes No

¹³If so, please explain briefly explain:

Office Use ONLY

Date Postmark:

Date Received:

Application/Contract No.:

Date Approved:

Approved Amount:

Use amounts from Page 7 worksheet to complete 14 – 17.

¹⁴ Total Estimated Expense:	\$	¹⁵ Business Match (10%):	\$	¹⁶ Total Amount Requested	\$	¹⁷ Estimated Amount per Employee:	\$
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NOTE on STARS Credit:
 Please provide standard course descriptions to ensure that the planned coursework is eligible for STARS credit.

Continuing Education Information

¹⁸Training Start Date: _____ ¹⁹Training End Date: _____ (Training must be completed in 6 weeks or less.)

²⁰Training City: _____ ²¹Training State: _____

²²Training Provider: _____

²³Training Title (Please provide a brochure or other documentation from the training provider): _____

²⁴Is this training CORE training for your child care business to be licensed? Yes No

²⁵Will this training upgrade a participant's skill level? Yes No

²⁶Are participants taking this training for STARS credit? Yes No

²⁷Can this training be completed in a maximum of six weeks? Yes No

²⁸Please list what competencies this proposed training will apply to:

<input type="checkbox"/> Health, Nutrition and Safety	<input type="checkbox"/> Family Relationships
<input type="checkbox"/> The active learning environment	<input type="checkbox"/> Program Management
<input type="checkbox"/> Child growth and development	<input type="checkbox"/> Professionalism
<input type="checkbox"/> Guidance and Discipline	<input type="checkbox"/> Uniqueness and Cultural Diversity

Continuing Education Budget for ALL Participants

	AMOUNT
²⁹ Total Registration, Tuition, Class Fees and Class Materials (Receipt Needed after training) \$ _____ x _____ # of people + \$ _____ x _____ # of people	\$
³⁰Participant Travel Expenses:	
^a Total Air Fare (Receipt Needed after training) Flying to Training-- City of Departure: _____ City of Arrival: _____ Flying Home from Training-- City of Departure: _____ City of Arrival: _____	\$
^b Roundtrip Mileage - Use www.mapquest.com to calculate your roundtrip mileage city to city Example: (1 car x 100 miles) x \$0.54 = \$54.00 ----- (_____ x _____) x \$0.54 = <div style="display: flex; justify-content: space-around; width: 100%;"> # of Vehicles Total Roundtrip Miles </div>	\$
^c Meals & Incidental Expenses (M&IE) for Travel and Training Days Use www.gsa.gov/perdiem to find your per diem rate Travel Day Example: 2 Travel Days Per Person x \$44.00 Per Diem Rate x 0.75 = \$66.00 Per Person Training Day Example: 2 Training Days Per Person x \$44.00 Per Diem Rate = \$88.00 Per Person Total Example: (\$66.00 pp travel + \$88.00 pp training) x 5 Trainees = \$770.00 ----- Per Person Travel Day: _____ x _____ x 0.75 = _____ Per Person <div style="display: flex; justify-content: space-around; width: 100%;"> # of Travel Days Per Diem Rate </div> Per Person Training Day: _____ x _____ = _____ Per Person <div style="display: flex; justify-content: space-around; width: 100%;"> # of Training Days Per Diem Rate </div> Total Amount Needed: (\$ _____ + \$ _____) x _____ = <div style="display: flex; justify-content: space-around; width: 100%;"> Per Person Travel Total Per Person Training Total Number of Participants </div>	\$
^d Lodging (Receipt needed after training) Example: (3 Nights x 2 Rooms) x \$102.00 = \$612.00 (_____ x _____) x \$ _____ = <div style="display: flex; justify-content: space-around; width: 100%;"> # of Nights # of Rooms Hotel Rate Per Night </div>	\$
^e Other Travel Expenses:	\$
³¹ Fees for Continuing Education Units/Certifications (Receipt needed after training)	\$
³² Total Estimated Expenses	\$
³³ Less Business Match (Total Estimated Expenses x .10 = Business Contribution)	\$
³⁴ Total Grant Amount Requested	\$
³⁵ Estimated Grant Amount per Employee (Total Grant Amount Requested ÷ Number of Participants)	\$

Continuing Education Budget for Trainer

ONLY FILL OUT THIS SECTION IF YOU ARE HOSTING A TRAINER AT YOUR FACILITY	AMOUNT
²⁹ Total Registration, Tuition, Class Fees and Class Materials <i>(Receipt Needed After Training)</i>	\$
³⁰Trainer Travel Expenses:	
^a Total Air Fare <i>(Receipt Needed After Training)</i> Flying to Training-- City of Departure: _____ City of Arrival: _____ Going Home From Training-- City of Departure: _____ City of Arrival: _____	\$
^b Roundtrip Mileage - Use www.mapquest.com to calculate your roundtrip mileage city to city Example: (1 car x 100 miles) x \$0.54 = \$54.00 ----- (_____ x _____) x \$0.54 = _____ <div style="display: flex; justify-content: space-around; width: 100%;"> # of Trainer Vehicles Total Roundtrip Miles </div>	\$
^c Meals & Incidental Expenses (M&IE) for Travel and Training Days Use www.gsa.gov/perdiem to find your per diem rate Travel Day Example: 2 Travel Days Per Person x \$44.00 Per Diem Rate x 0.75 = \$66 Per Person Training Day Example: 2 Training Days Per Person x \$44.00 Per Diem Rate = \$88 Per Person Total Example: (\$66 pp travel + \$88 pp training) x 5 Trainees = \$770 ----- Per Person Travel Day: _____ x _____ x 0.75 = _____ Travel Total <div style="display: flex; justify-content: space-around; width: 100%;"> # of Travel Days Per Diem Rate </div> Per Person Training Day: _____ x _____ = _____ Training Total <div style="display: flex; justify-content: space-around; width: 100%;"> # of Training Days Per Diem Rate </div> Total Amount Needed: \$ _____ + \$ _____ = \$ _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Travel Total Training Total </div>	\$
^d Lodging <i>(Receipt needed after training)</i> Example: (3 Nights x 2 Rooms) x \$102.00 = \$612.00 (_____ x _____) x \$ _____ = \$ _____ <div style="display: flex; justify-content: space-around; width: 100%;"> # of Nights # of Rooms Hotel Rate Per Night </div>	\$
^e Other Travel Expenses:	\$
³¹ Fees for Continuing Education Units/Certifications <i>(Receipt needed after training)</i>	\$
³² Total Estimated Expenses	\$
³³ Less Business Match (Total Estimated Expenses x .10 = Business Contribution)	\$
³⁴ Total Grant Amount Requested	\$
³⁵ Estimated Grant Amount per Employee (Total Grant Amount Requested ÷ Number of Participants)	\$

Participant Information (All participants must work a *minimum of 15 hours per week.*)

³⁶ First Name	³⁷ Last Name	³⁸ SSN	³⁹ STARS ID #	⁴⁰ Current Rate of Pay	⁴¹ Est Rate of Pay After Training	⁴² Average Number of Hours Worked Weekly

Checklist:

Please check to ensure you have completed each of the following. If you are unable to check yes on any of the following items, your application will be denied.

Application for WY Quality Counts! Services submitted no less than 45 days and not more than 110 days prior to beginning of coursework / training event: Application Due Date Calculator at: http://wyqualitycounts.org/providers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brochure or advertisement for the requested training attached.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Application complete.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature(s)

Child Care Provider Owner/Director Signature

I certify that the employee(s), on page 9, is/are:

- Employed for a minimum of 15 hours per week.
- I also certify that the employee(s), on page 9, are all 18 years of age or older. (If under 18 years of age signature of parent will be required.)
- That the information in this application is true and accurate to the best of my knowledge.
- The current Wyoming Department of Family Services approved capacity in my program is _____, and my current enrollment count is_____.

I am aware that any false information or intended omissions may subject me or my company to civil or criminal penalties for filing false public records, and may result in forfeiture of any grant award approved through this program.

Child Care Provider Owner /Director Signature Date

Printed Name