

# Family Child Care Home Guidance for SC Building Blocks Grant Application

**\*\*IMPORTANT: Information in this application is pulled directly from DSS Systems. If any information, such as hours of operation or quality level, has changed please contact your Child Care Licensing Specialist or ABC Quality Assessor BEFORE submitting your application. \*\***

## Step 1

CC Number: \*  
CC999992

Enter your CC number. This is the same number you use to obtain your SLED/FBI background checks. If you are unsure what your number is, you can contact your Child Care Licensing Specialist.

## Step 2

### Family/Group Child Care Home Details

Provider Name: \*  
Test Home 2

Permit Number:  
999992

Facility Type: \*  
FCCH

Capacity:  
6

Street Address: \*  
1628 Browning Rd

City: \*  
Columbia

State: \*  
SC

Zip Code: \*  
29212

County: \*  
RICHLAND

ABC Quality Level:  
A

Initial License Date: \*  
02/12/2017

Equity Index: \*  
Located in equity index 1 area

This information is automatically added from DSS system. Review Details for accuracy. If any information is incorrect, please contact your Child Care Licensing Specialist.

Equity Index is determined by the county your facility resides in. For more details on Equity Index visit [www.sccildcare.org](http://www.sccildcare.org).

## Step 3

### Operator/Director Details

Operator/Director First Name: \*

Operator/Director Last Name: \*

Operator/Director Contact Email: \*

Phone Number: \*

Operator/Director Race: \*

Operator/Director Ethnicity: \*

Operator/Director Gender: \*

+ Add additional Operator/Director

Enter Director or Operator contact details.

If more than one Operator click the button to enter details for second person.

### Example Step 3:

**Operator/Director Details**

|   |  |                                       |
|---|--|---------------------------------------|
| Operator/Director First Name: *<br>Tabitha              | Operator/Director Last Name: *<br>Dearling   |                                       |
| Operator/Director Contact Email: *<br>myemail@email.com | Phone Number: *<br>8035555555                |                                       |
| Operator/Director Race: *<br>Multiracial                | Operator/Director Ethnicity: *<br>Not Latino | Operator/Director Gender: *<br>Female |

+ Add additional Operator/Director

### Step 4

**Operational Status**

Was your program licensed/registered/certified/regulated on or before March 11, 2021?: \*

Is your program currently enrolled in ABC Quality?: \*

Is your facility licensed to serve infants?: \*

Is your program currently enrolled in the SC Endeavors Work Force Registry and completed their Organization Profile?: \*

Is your program currently enrolled in CACFP?: \*

Please supply your CACFP Agreement Number: \*

You are not currently eligible to apply for this grant. Please contact SC Endeavors to enroll to become eligible for this grant.

What is the current status of your program?: \*

Open

Answers to questions populated from DSS systems will appear greyed out.

Some questions will require further information to verify even if the yes/no answer was already greyed out

Status of the facility is supplied by Child Care Licensing, if this is not correct, please call and update your Specialist.

Questions that require an answer will be full color. Click on the button to change the answer to "Yes"

Yes

Yes

No

No

Yes

Yes

## If Temporarily closed:

You are currently eligible to apply for this grant.

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: \*  
closed due to cleaning, plan to re-open

Planned Reopen Date: \* 01/30/2022

Reopen date needs to be within 30 of applying or you will only receive one twelfth of your eligible payments.

If temporarily closed due to Covid19 you can still apply, but you must re-open within 30 days from the date of notification of payment from the state accounting system (SCEIS).

Update your Child Care Licensing specialist when you have re-opened

## Step 5

What is the licensed or identified capacity of your program?:

6

**Day of the Week Hours of Operations Total Operating Hours**

|           |     |    |
|-----------|-----|----|
| Monday    | 6-6 | 24 |
| Tuesday   | 6-6 | 24 |
| Wednesday | 6-6 | 24 |
| Thursday  | 6-6 | 24 |
| Friday    | 6-6 | 24 |
| Saturday  | 6-6 | 24 |
| Sunday    | 6-6 | 24 |

Review Hours of Operation.

If this is not correct, stop the application, and update you Licensing Specialist immediately.

Operates 24 Hours: \*



Yes

Operates Over Night: \*



Yes

Does your facility operate over weekends? \*



Yes

## Step 6

|  |   |  |
|--|---|--|
| <p>Number of recipients of voucher enrolled:<br/>6</p> <p>What is your current average enrollment by age?</p> <p>0 years of age* _____</p> <p>1 year of age* _____</p> <p>2 years of age* _____</p> <p>3 years of age* _____</p> <p>4 years of age* _____</p> <p>5 years of age not in Kindergarten* _____</p> <p>5 years of age in Kindergarten or older* _____</p> <p>Total Average Enrollment: *0</p> | <p>Number of recipients of voucher paid in the last two years:<br/>12</p> | <p>What was your average enrollment by age in January 2020 (before COVID-19)?</p> <p>0 years of age* _____</p> <p>1 year of age* _____</p> <p>2 years of age* _____</p> <p>3 years of age* _____</p> <p>4 years of age* _____</p> <p>5 years of age not in Kindergarten* _____</p> <p>5 years of age in Kindergarten or older* _____</p> <p>Total Pre-COVID Average Enrollment: *0</p> |
|--|---|--|

All lines must have a number. If no children enrolled at that age then place a 0 on the line

All lines must have a number. If no children enrolled at that age then place a 0 on the line

### Example Step 6:

0 years of age\*  
0

---

1 year of age\*  
2

---

2 years of age\*  
0

---

3 years of age\*  
2

---

4 years of age\*  
0

---

5 years of age not in Kindergarten\*  
2

---

5 years of age in Kindergarten or older\*  
0

---

Total Average Enrollment: \*6

## Step 7

Base Funding

Type of facility: \*  
Family Child Care Home

What is your current ABC Quality level? \*  
A

Total Base Funding Amount:  
\$45,000.00

All Information in this section is pulled from DSS Systems, if incorrect contact the corresponding program to update before submitting application.

## Step 8

Supplemental Funding

Number of recipients of vouchers paid in the last two years: \*  
12

Number of recipients of vouchers currently enrolled: \*  
6

Are you located in an area that qualifies for equity supplement? \*  
RICHLAND

Located in equity index 1 area

Is your facility open overnight, twenty-four hours, or weekends? \*  Yes  No

Is your program currently enrolled in the Child and Adult Care Food Program (CACFP)? \*  Yes  No


Total Supplemental Funding Amount:  
\$53,500.00

Information pulled from DSS Systems, if incorrect contact the corresponding program to update before submitting application.

## Step 9

Total Funding

Total Potential Funding:  
\$98,500.00

Do you agree to the staff compensation expectation? \*  Yes  No 

Funding you must allocate to staff compensation:

Total Funding Amount:

Answer "yes" to opt in for staff compensation options. If "no", then facility is only eligible for 75% of the potential funding amount.

### Example Step 9:

Total Funding

Total Potential Funding:  
\$98,500.00

Do you agree to the staff compensation expectation? \*  Yes  No i

Funding you must allocate to staff compensation:  
\$24,625.00

Total Funding Amount:  
\$98,500.00

If you answered "Yes" to staff compensation options, the system will show you the amount that should be allocated to staff compensation options.

### Step 10

- Funds Use Categories Information

|   |            |                    |  |
|---|------------|--------------------|--|
| Personnel Costs:  | 25%        | \$24,625.00        | <span style="border: 1px solid blue; border-radius: 50%; padding: 2px;">i</span> |
| Rent, utilities, facility maintenance, and insurance:                           | 00%        | \$0.00             | <span style="border: 1px solid blue; border-radius: 50%; padding: 2px;">i</span> |
| Personal Protective Equipment, Cleaning, and other health and safety practices: | 00%        | \$0.00             |  |
| Equipment and Supplies:   | 00%        | \$0.00             |  |
| Goods and Services:   | 00%        | \$0.00             | <span style="border: 1px solid blue; border-radius: 50%; padding: 2px;">i</span> |
| Mental Health Services:   | 00%        | \$0.00             | <span style="border: 1px solid blue; border-radius: 50%; padding: 2px;">i</span> |
| Past Expenses:  | 00%        | \$0.00             | <span style="border: 1px solid blue; border-radius: 50%; padding: 2px;">i</span> |
| <b>Total:</b>   | <b>25%</b> | <b>\$24,625.00</b> |  |

Percentage should be 100, to submit the application.

If yes to staff compensation, then 25% is already marked for personnel costs and must remain there.

Determine the percentage of the funds that you will use in each Category

Circles explain allowable use of funds in each section.

Total percentage must equal 100% to be able to submit the application

### Example Step 10:

Total: 100% \$98,500.00

### Step 11

- To receive a stabilization grant, I agree to use the funds only for the categories and purposes indicated on this application and have marked above which categories I plan to fund. Note: You can move funds between categories without prior approval.\*
  - 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. Providers will maintain documentation supporting the expenditure of grant funds which may include records of application approval, receipts, invoices, and/or any other supporting documentation indicating how funds were used. Documentation must remain on file at the facility for a period of three (3) years from the date the grant is completed as needed to satisfy a possible audit. Documentation may be requested at any time by DSS and, if requested, will need to be provided within fifteen (15) calendar days of the request. If funds are determined not to be used for purchases according to the definition of operating expenses provided, recoupment of the funds will be initiated.\*
- By signing this application, I am 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 involuntarily furlough employees from the date of application submission through the duration of the subgrant period.\*
  - C. I will provide relief from copayments 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.\*
  - I will agree to meet quarterly reporting requirements as set forth by the South Carolina Department of Social Services.\*
  - ← All confirmation boxes must be checked to be able to submit application

### Step 12

Signature First Name: \* \_\_\_\_\_ Signature Last Name: \* \_\_\_\_\_ Email Address: \* \_\_\_\_\_

Signature First Name is required      Signature Last Name is required      Signature Email is required

Please sign in the space provided below by left clicking and moving your mouse.\*

← Sign by left clicking on your mouse and moving the cursor.

### Example Step 12:

Signature First Name: \* \_\_\_\_\_ Signature Last Name: \* \_\_\_\_\_ Email Address: \* \_\_\_\_\_

Tabitha      Darling      myemail@email.com

Signature First Name is required      Signature Last Name is required      Signature Email is required

Please sign in the space provided below by left clicking and moving your mouse.\*

Tabitha Darling


## Step 13

Provider Submitted Application for Grants successfully with reference number **DFIO000031**. Please hold on to this reference number for future purposes.

Reference Number  
DFIO000031

[Go Home](#)

**IMPORTANT:** Keep this Reference number to check updates to the application and to provide verification of use of funds.

 Red Starred items must be filled out before the application can be submitted

**Questions about the SC Building Blocks grant?**

Email [scstabilizationgrant@dss.sc.gov](mailto:scstabilizationgrant@dss.sc.gov) or call Tameka Pauling at (800)476-0199.

**Need help completing the SC Building Blocks Grant application or need assistance in planning how to use the grant funding?**

Call the SC Child Care Resource and Referral Network at (888)335-1002 or complete a web referral at [www.sc-ccrr.org](http://www.sc-ccrr.org).