

# PROFESSIONAL DEVELOPMENT/PROGRAM IMPROVEMENT FUNDS



## APPLICATION (July 2007 – June 2008)



### Child Care Resource & Referral, John A. Logan College

- I am applying:  As an individual and/or for program accreditation (complete ALL STEPS of the Application)  
 On behalf of a center or association (complete Application steps 1 – 4, 6)

Please refer to Professional Development/Program Improvement Funds Application 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  Pre-K  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**

One Funding Request per application. Please mark your selection below:

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

| REASON   | TUITION | WORKSHOP/<br>CONFERENCE/<br>OFF-SITE<br>TRAINING | Assessment<br>Tools | CREDENTIALING<br>PROGRAM | ACCREDITATION | ON-SITE<br>IN-SERVICE/<br>GROUP<br>TRAINER FEE |
|--|---------|--|---------------------|--------------------------|---------------|--|
| Implement better practices                       |         |  |                     |                          |               |  |
| Meet DCFS training requirements                  |         |  |                     |                          |               |  |
| Obtain qualifications for a new position         |         |  |                     |                          |               |  |
| Earn training hours for a credential             |         |  |                     |                          |               |  |
| Earn training hours to renew a credential        |         |  |                     |                          |               |  |
| Earn college coursework credit                   |         |  |                     |                          |               |  |
| Increase my level to receive a Great START bonus |         |  |                     |                          |               |  |
| Meet accreditation standards                     |         |  |                     |                          |               |  |
| Other _____                                      |         |  |                     |                          |               |  |

**INDIVIDUAL OPTIONS:** *The maximum amount of funds that can be reimbursed to an individual from PDF/Improvement Funds during FY '08 is \$500. Everyone who receives PDF may be responsible for paying a copayment based on their family size and income. Complete the supplemental page attached.* (Refer to Guidelines & Requirements, Page 1, #2, #3A)

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

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 for this course? \_\_\_\_ Type of hours:  Semester Hours  Quarter Hours

Type of credit:  Undergraduate  Graduate

| Total Amount(s) Requested               | \$ | Limit/Max                  |
|---|----|----------------------------|
| <input type="checkbox"/> Tuition        |    | Maximum up to \$500 per FY |
| <input type="checkbox"/> Required Books |    | Up to \$60 Per class       |

**B.  WORKSHOP/CONFERENCE/OFF-SITE TRAINING** (Refer to Guidelines & Requirements, Page 2, #3B)

(Attach conference announcement and/or outline and description of conference).

Name of event: \_\_\_\_\_ Date(s) attending: \_\_\_\_\_

Location: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Number of training hours you expect to receive: \_\_\_\_\_

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(s) Requested   | \$ | Limit/Max                         |
|---|----|-----------------------------------|
| <input type="checkbox"/> Workshop/Conference/Off-Site Training Registration Fee |    | Basic Conference fee max: \$500   |
| <input type="checkbox"/> Lodging (based on minimum double occupancy)            |    | Up to \$100 per person/ per night |

**C.  CREDENTIALING PROGRAM (Please check category below)** (Refer Guideline & Requirements, Page 2, #3C)

| Total Amount(s) Requested   | \$ | Limit/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) Application Fee           |    | \$25        |
| <input type="checkbox"/> Illinois Director Credential (IDC) Transcript Evaluation Fee |    | \$200       |
| <input type="checkbox"/> Illinois Director Credential (IDC) Portfolio Assessment Fee  |    | \$300       |
| <input type="checkbox"/> Illinois Director Credential (IDC) Level Advancement Fee     |    | \$50        |
| <input type="checkbox"/> Certified Childcare Professional (CCP) Assessment Fee        |    | \$495       |
| <input type="checkbox"/> Credential Renewal Fee                                       |    | Up to \$50  |
| <input type="checkbox"/> Credentialing Information Packet                             |    | Up to \$50  |
| <input type="checkbox"/> Credential Advisor   |    | Up to \$500 |
| <input type="checkbox"/> CARE Courses   |    | Up to \$500 |
| <input type="checkbox"/> Membership Fee (limited to CDA candidates)                   |    | Up to \$55  |

- 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

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

**D.  ACCREDITATION (Please check category below)** (Refer to Guidelines & Requirements, Page 3, #3D)

| Total Amount(s) Requested   | \$ | Limit/Max   |
|---|----|-------------|
| <input type="checkbox"/> NAFCC Application Fee  |    | \$495       |
| <input type="checkbox"/> NAEYC Step 1: Enrolling in self study (Program Capacity _____) |    | Up to \$500 |
| <input type="checkbox"/> NAEYC Step 2: Becoming an applicant (Program Capacity _____)   |    | Up to \$500 |
| <input type="checkbox"/> NAEYC Step 3: Becoming a candidate (Program Capacity _____)    |    | Up to \$500 |
| <input type="checkbox"/> NECPA Application Fee (Program Capacity _____)                 |    | Up to \$500 |
| <input type="checkbox"/> NECPA Verification Fee (Program Capacity _____)                |    | Up to \$500 |
| <input type="checkbox"/> NAA Intent to Submit Fee                                       |    | Up to \$500 |
| <input type="checkbox"/> NAA Application Submission, Review and Processing Fee          |    | \$300       |
| <input type="checkbox"/> NAA Endorsement Visit, Report Review and Processing Fee        |    | \$450       |
| <input type="checkbox"/> NAC Application Fee (Program Capacity _____)                   |    | \$350       |
| <input type="checkbox"/> NAC Validation Fee (Program Capacity _____)                    |    | Up to \$500 |
| <input type="checkbox"/> Accreditation Mini-Grant (equipment and materials)             |    | \$500       |
| <input type="checkbox"/> Accreditation Mentor/Consultant (# of hours _____)             |    | Up to \$500 |
| <input type="checkbox"/> Accreditation Annual Report Fee                                |    | Up to \$500 |
| <input type="checkbox"/> Accreditation Information Packet                               |    | Up to \$500 |

Please consult Nina at 800-232-0908, if your request does not match the above listed categories.

**E.  ASSESSMENT TOOLS** Limit one of each scale that is appropriate to the program's services.  
 (Refer to Guidelines & Requirements, Page 3, #3E)

| Total Amount(s) Requested   | \$ | Limit/Max   |
|---|----|-------------|
| <input type="checkbox"/> Family Child Care Environmental Rating Scale (FCCRS-R) |    | \$25        |
| <input type="checkbox"/> Infant/Toddler Environmental Rating Scale (ITERS-R)    |    | \$25        |
| <input type="checkbox"/> Early Childhood Environmental Rating Scale (ECERS-R)   |    | \$25        |
| <input type="checkbox"/> School Age Care Environment Rating Scale (SACERS)      |    | \$25        |
| <input type="checkbox"/> Program Administrator Scale (PAS)                      |    | \$25        |
| <input type="checkbox"/> ERS Resource materials (e.g., books, VHS/DVD)          |    | \$75        |
| <input type="checkbox"/> Assessment Mentor/Consultant (# of hours _____)        |    | Up to \$500 |

**GROUP OPTIONS:** The maximum amount of funds that can be reimbursed to a program/association from PDF funds during FY '08 is \$500.

**F.  ON-SITE IN-SERVICE/GROUP TRAINER FEE** – attach brochure and/or outline and description of training  
 (Refer to Guidelines & Requirements, Page 4, #3F)

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  | \$ | Limit/Max   |
|---|----|-------------|
| <input type="checkbox"/> On-Site In-Service/Group Trainer Fee |    | Up to \$500 |

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

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

Total Estimated Expenses \$ \_\_\_\_\_

- 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 or FEIN Number (REQUIRED): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Total Estimated Expenses (Use only if multiple requests): \$ \_\_\_\_\_

- 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 or FEIN Number (REQUIRED): \_\_\_\_\_ Phone Number \_\_\_\_\_

**STEP 5: Narrative Requirements (for individual and program improvements applicants only)**

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)  
 TEACH                                       IDHS Grants                                       United Way                                       employer match  
 SAM Program                                       Other (please specify) \_\_\_\_\_
- 3) For credential and accreditation funds, please attach a written timeline that describes how you will reach your goal of accreditation and/or credentialing.
- 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 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 \_\_\_\_\_

**Return application and all required documents to:**

**CCR&R**  
**Nina Wargel**  
**700 Logan College Rd**  
**Carterville, IL 62918**

**PROFESSIONAL DEVELOPMENT/PROGRAM IMPROVEMENT FUNDS  
APPLICATION (July 2007-June 2008)**

Child Care Resource and Referral, John A. Logan College



**Supplemental Page**

Any individual who receives Professional Development Funds will be responsible for paying a copayment for training based on their family size and income. The following section must be completed for this application to be considered. An individual will be notified of the co-payment amount in the approval letter.

Mark the area of your Gross Family Income:

| Family Size | \$10 or 10%                           | \$20 or 15%                          | \$30 or 20%                           | \$40 or 30%                          |
|-------------|---------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|
| 1           | <input type="checkbox"/> 0 - \$19,331 | <input type="checkbox"/> To \$32,786 | <input type="checkbox"/> To \$47,178  | <input type="checkbox"/> > \$47,178  |
| 2           | <input type="checkbox"/> 0 - \$24,605 | <input type="checkbox"/> To \$41,829 | <input type="checkbox"/> To \$61,513  | <input type="checkbox"/> > \$61,513  |
| 3           | <input type="checkbox"/> 0 - \$30,395 | <input type="checkbox"/> To \$51,671 | <input type="checkbox"/> To \$75,987  | <input type="checkbox"/> > \$75,987  |
| 4           | <input type="checkbox"/> 0 - \$36,184 | <input type="checkbox"/> To \$61,513 | <input type="checkbox"/> To \$90,460  | <input type="checkbox"/> > \$90,460  |
| 5           | <input type="checkbox"/> 0 - \$41,973 | <input type="checkbox"/> To \$71,355 | <input type="checkbox"/> To \$104,934 | <input type="checkbox"/> > \$104,934 |
| 6           | <input type="checkbox"/> 0 - \$47,763 | <input type="checkbox"/> To \$81,197 | <input type="checkbox"/> To \$122,122 | <input type="checkbox"/> > \$122,122 |

Name: \_\_\_\_\_

Date: \_\_\_\_\_