Early Learning Coalition
Indian River • Martin • Okeechobee

Expand Your Center, Curriculum, & CPR Grant Application

Program Year 2023 – 2024

Please print and fill out completely.

Application will be rejected if not completed in its entirety.

1. Provider Information

Name of Provider: _____

Address: _____
Street Name

_____
City/State/Zip *County*

Director: _____ Phone: _____ Email: _____

Contact Person (if different from Director): _____

Contact Phone: _____ Contact Email: _____

What is your current CLASS Composite Score? _____

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2. Select Bonus – *Check ALL that you are applying for.*

☐ **Expand Your Center (up to $30,000 per additional classroom)**

- *Grant is for additional classrooms ONLY.*
- *Provider must have a CLASS Compsite Score of 5.00 or higher as of date of application/application deadline.*
- *Must use an existing space – cannot add square footage to facility.*
- *Expansion must be completed with DCF License (capacity) updated by June 30, 2024.*
- **Priority given to Infant Classrooms.*

☐ **Infant** How many Infant classrooms would you like to add? _____

☐ **Toddler** How many Toddler classrooms would you like to add? _____

☐ **PreK** How many PreK classrooms would you like to add? _____

☐ **VPK** How many VPK classrooms would you like to add? _____

****Attached to the email with this application, you must include proof of waitlist(s) or other documentation to support the request to expand.**

Provide an estimated preliminary budget per additional classroom, detailing what changes/renovations are necessary and what materials will need to be purchased to add more slots for children. If more space is needed, please attach a document to the email. *(More information may be requested upon application review.)*

☐ **Curriculum Reimbursement**

- *Training for ALL Directors and Teachers is required following the purchase of curriculum.*
- *Curriculum must be purchased between July 1, 2023 and June 30, 2024.*

What DEL approved curriculum will be purchased? _____

Select all age level(s) being purchased and how many of each.

☐ Infant #_____ ☐ Toddler #_____ ☐ PreK/VPK #_____

☐ **CPR Reimbursement**

- Provider will be reimbursed based upon Red Cross Fee Schedule. https://www.redwhitebluecpr.com/classes-and-pricing

# of Staff to be Trained: _____

3. Attestation Statement:

I have read over this application to ensure completeness and correctness and have made a copy of this application for my own records.

Authorized Representative

Name: _____ Email: _____

Signature: _____ Date: _____

_____ *(Initial Here) I confirm that this scanned 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.*