

West Virginia Child Care Stabilization Payment Certification Agreement

American Rescue Plan (ARP) Act Child Care Funding

Provider Name:			
Program/Facility Name:			
Mailing Address:		County:	
City, State, Zip:			
Phone Number:		Email Address:	
<input type="checkbox"/> Center (select type: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Type III)	<input type="checkbox"/> Family CC Home	<input type="checkbox"/> Family CC Facility	<input type="checkbox"/> OST Center
Applicant Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Black/African American <input type="checkbox"/> Multiracial	
Applicant Ethnicity:	Applicant Latino: <input type="checkbox"/> yes <input type="checkbox"/> no	Applicant Gender:	

Use of Funds

Please refer to the West Virginia Child Care Stabilization Payment Policy and Procedure Manual, Chapter 3: Acceptable Use of Stabilization Payments, for definitions of the below categories.

<https://dhhr.wv.gov/bcf/ece/policies/Pages/default.aspx>

To receive a Child Care Stabilization Payment, I agree to use the funds only for the following:
(Select all that apply)

- Personnel costs
- Rent or mortgage payments
- Insurance
- Facility maintenance and improvements
- Personal protective equipment (PPE) and COVID-related supplies
- Training and professional development related to health and safety practices
- Goods and services needed to resume providing care
- Mental health supports for children and early educators
- Reimbursement of costs associated with the COVID-19 Pandemic

Certification

Please read and initial each statement below:

_____ I 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 below.

By signing this agreement, I am certifying that I will meet requirements throughout the period of the Child Care Stabilization Payments, October 1, 2021, through September 30, 2023, including the following:

_____ I understand that I must be open and providing full day child care services in West Virginia to the community. A full day is defined as at least eight consecutive hours. Out of School Time Programs are exempt from the eight-hour requirement.

_____ 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).

_____ 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 throughout the duration of the subgrant period.

_____ To the extent possible, I will provide relief from copayments and tuition payments for the families enrolled in the child care program and prioritize such relief for families struggling to make either type of payment. If I am unable to provide relief from copayments and tuition payments for all families enrolled in my program, I will prioritize doing so for families most in need of relief and target families earning below 85 percent of the State Median Income.

_____ I must abide by my Provider Services Agreement and maintain compliance with licensing and regulatory requirements.

_____ I understand that billing for unapproved services may result in legal action for repayment and prosecution for fraud. If there is substantiated misrepresentation by a provider that provider shall be prohibited from receiving Child Care Stabilization Payments.

_____ I agree that the West Virginia Department of Health and Human Resources and any of its authorized representatives shall have the right of access to any documents, papers, or other records which are related to the Child Care Stabilization Payments, in order to make audits, examinations, excerpts, and transcripts. The right also includes timely and reasonable access to the program personnel for the purpose of interview and discussion related to such documents. The rights of access are not limited to the required retention period but last as long as the records are retained.

The following signature affirms that I will adhere to the items noted above. It also affirms I will only use the funds in the areas noted. I understand that I must keep records and receipts to verify expenditures, and I understand that I may be required to repay any funds used for unapproved purposes.

Signature

Printed Name

Date

FAILURE TO RETURN THIS FORM TO ECEProviders@wv.gov BY NOVEMBER 15, 2021, WILL RESULT IN DISCONTINUATION OF CHILD CARE STABILIZATION PAYMENTS.