



Continuous Quality Improvement Grant Provider Application

The purpose of this funding is intended to positively affect outcomes for children at scale by improving adult-child interactions through training early learning teachers, staff, and administrators to support CLASS implementation at SR and/or VPK contracted providers with a CLASS composite score of 5 or higher.

SR and/or VPK contracted providers will have the opportunity to apply for funding to develop/implement a program to:

- Support effective interactions, and/or
- Strengthen business and leadership practices, and/or
- Support child assessment and screening with reliability, and/or
- Support other local priorities.

Providers must strategically target these efforts to support the needs of their programs, families, and staff.

I. Provider Information

Name of Provider: _____ Provider ID: _____

City/State/Zip: _____

Director: _____ Email: _____ Phone: _____

Contact Person (if different from Director): _____

Phone: _____ Contact email address: _____

II. Eligibility Criteria

Please enter the requested information below:

CLASS Observation Date: _____ CLASS Composite Score: _____

III. Training Plan

Please provide a brief overview of your training plan, including priorities, weekly goals, and planned outcomes.

Programs must provide a minimum of 24 hours of training time for directors and staff. Training can include live coaching, live or virtual instruction, individual and group instruction, and other competency-based skill development exercises. Please provide the following information about the course/training(s) to be utilized in your training plan.

Course Title	Course Provider/ Vendor	Course Description	Training Format (Live Coaching, Live Instruction, Virtual Coaching, Virtual Instruction, etc.)	Course Cost	Hours
Total Number of Hours (must equal 24 or more hours of training)					

Training Plan Start Date: _____

Training Plan End Date: _____

VI. Provider Attestations:

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

Signature of Authorized Representative

Name: _____ Email: _____

Signature: _____ Date: _____

I confirm that this electronic 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.

VII. Application Information Provided to/Processed by – completed by ELC/RCMA staff:

- Yes No Is this application form complete?
- Yes No Have you verified the provider has a current SR and/or VPK contract?
- Yes No Have you verified the providers current CLASS® score?
- Yes No Have you verified the provider is not under investigation or been convicted of child care fraud?
- Yes No Have you verified that the provider is not on the Florida Child Care Food Program (CCFP) USDA Disqualified List?
- Yes No Have you verified your entity is the “home” coalition for this provider?

If all above responses are “yes,” this application form can be accepted.

Signature of ELC/RCMA Representative

Signature: _____

Contact Name: _____ Date: _____

Contact Phone: _____ Email: _____

Contact Entity: Early Learning Coalition RCMA Other _____

CQI Grant Amount \$ _____ (OCA: ASQIG)