VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

IMPORTANT!

This **sample** application includes sections for up to four children, resulting in a 30-page document. If you are entering information for fewer children, the length of your application will be significantly shorter. Don't be overwhelmed by the sample—focus on completing only the sections that apply. This is a sample application only.

Special Accommodations Grant (SAG) Child Development Division

The Agency of Human Services, Department for Children and Families, Child Development Division (referred to as the "State") invites Vermont Regulated Specialized Child Care Programs to apply for funds to support the safe and successful inclusion of one or more children in their program.
These funds are designed to support the safe and successful inclusion, access, and participation of one or more children with identified needs in your group or classroom. You have the flexibility to apply for grant funds to purchase specialized equipment or materials, provide consultation, training, or coaching for your child care staff tailored to the child/children's needs, and/or hire an Inclusion Support Staff member. This Inclusion Support staff member will work with all children in your classroom to support the safe participation and engagement of the child or children identified in your application.
Specialized Child Care Programs (SCC) must be in compliance with their SCC Agreement and in good standing* with Vermont child care licensing regulations. SCC programs may apply on behalf of one or more children with identified needs who require additional support to access or remain enrolled in their program. Child care programs should complete the SAG application in partnership with the child's team, which includes the child's parent/caregiver and the professionals working together to support the child's successful inclusion within the program.

Necessary Application Process Steps:

1. Read the Request for Grant Applications (RFGA for SAG), which provides details about timelines, eligibility requirements, required documentation, and grant specifications. You will also find detailed SAG Application guidance, which outlines essential highlights in the RFGA and is available to print out.
2. Meet with the parent/guardian to review and sign the Children's Integrated Services (CIS) SAG Parent/Guardian Consent Form. The consent form should specify the people on the child's team who will contribute information to support this application request (i.e., the provider completing the letter of support on behalf of the child). A copy of the signed form must be included with your application.
3. Please email the following SAG Service/Health Provider Letter of Support form to a service/health provider who can speak to the child's needs. When the service/health provider completes the form, it will automatically be sent to the Child Development Division and added to your application.

Required Attachments

- **CIS SAG Parent/Guardian Consent Form** – Required to be uploaded for each child named in the application.
- **SAG Service/Health Provider Letter of Support Form** – Only needs to be upload into the application if the provider did not submit through the JotForm process and provided you with the PDF version of the form.
- **Child(ren)'s Plan(s)** - An active or interim One Plan, Individual Educational Plan, EST plan, 504 Plan, or Mental Health treatment plan that addresses their specialized need(s) within the past 6 months. If a child does not have a formal plan in place, the application must include supporting evidence, such as referrals made on behalf of the child, along with any screenings, assessments, or evaluations that demonstrate the child's need for additional support.
- **Certificate of Insurance** – Must be consistent with the requirements outlined in Attachment C, Section 8 (Insurance), and any additional insurance requirements set forth elsewhere in the RFGA.
-

W-9 IRS – Must be signed within the last six (6) months.

- **Unique Entity ID (UEI)**
  – Applicants are required to have a UEI assigned by registering on SAM.gov.
    - Suppose you have requested a UEI but have not yet received it. In that case, you will need to provide a copy of the email from SAM.gov showing that you have requested the UEI and/or the help desk email confirmation regarding any follow-up on the issuance of a UEI.
    - If your UEI is in process, please upload a signed and dated Certification of Suspension and Debarment.
    - If you have a UEI, but your SAM registration is not active, please upload a signed and dated Certification of Suspension and Debarment.

Questions and Technical Support

Please review the SAG Application Guidance for questions pertaining to the jot form application, along with guidance pertaining to the SAG application. The RFGA will explain what you will need to have ready to complete the SAG application. If you still have questions or need technical support, please join our weekly applicant information sessions (link below).
APPLICANT INFORMATION SESSIONS: A Specialized Child Care Program Administrator or Designee will be available to assist applicants every Thursday beginning August 22, 2024, from 12 to 1 p.m. unless otherwise posted.
The link to the weekly reoccurring SAG Application Hour is :
Join the meeting now
Meeting ID: 236 807 149 694
Passcode: DmS9R9

Dial in by phone
+1 802-552-8456,601612057# United States, Montpelier
Find a local number
Phone conference ID: 601 612 057#
For organizers: Meeting options | Reset dial-in PIN

Before You Proceed with the Application

Before proceeding with the application, please note the following:

- The application could take 30 to 60 minutes to complete.
  - You can **save and continue later** at any time by clicking the **Save** button at the bottom of the page. In order to save, you will be required to create a JotForm account (if you don't already have one) using an existing Google or Facebook account, or your email.
- Please have the **Required Attachments** (see previous page) saved to your computer and ready to upload into this application.

Please verify the following: *

- ☐ I have read and reviewed the RFGA CDD-SAG 08-19-24.
- ☐ I have a completed CIS Parent/Guardian Authorization Consent form for each child to be named in this application.

Organization/Program Information

Point of Contact

Responsible for answering questions regarding this application information.

Point of Contact's Name *

First Name Last Name

Point of Contact's Job Title *

Point of Contact's Phone Number *

Please enter a valid phone number.

Point of Contact's Email *

example@example.com

Organization/Program

Are you applying for more than one regulated child care program? *

- Yes
- No

Organization/Program's Physical Address *

Street Address

Street Address Line 2

Organization/Program's Mailing Address (if different than physical)

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

State of Vermont Vision Supplier ID *

Please see the FAQs for instructions of how to locate at https://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=57470

VT Business ID # *

If you are unsure of your ID #, you can search for it on the Vermont Secretary of State's website at https://bizfilings.vermont.gov/online/BusinessInquire/.

Child(ren) Information

How many children are part of this application? *

Please Select

Child 1

Child & Family Information

Child 1 *

First Name Last Name

Child 1 Date of Birth *

Month Day Year

Child 1 Primary Physical Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Parent/Legal Guardian's Name *

First Name Last Name

Is the parent/legal guardian's primary physical address different than the child's? *

- ◯ Yes
- ◯ No

Phone Number *

Please enter a valid phone number.

Email *

example@example.com

Does this child/family have an open or custody case with the Family Services Division (FSD)? *

- ◯ Yes
- ◯ No

Does the child/family receive Child Care Financial Assistance? *

- ◯ Yes
- ◯ No

Does the child/family have health insurance? *

- ◯ Medicaid
- ◯ Private
- ◯ Both Medicaid and Private
- ◯ Uninsured

Has this child been supported previously by SAG funding in your program? *

- ◯ Yes
- ◯ No

Child's Schedule

Is this child currently attending your program? *

- ◯ Yes
- ◯ No - Unable to access without additional supports.

Learning About the Child

Does the child have a current medical, developmental, or mental health condition or diagnosis? *

- ◯ Yes
- ◯ No
- ◯ Unsure

Has the child's medical, behavioral, and/or developmental needs impacted the child's placement within your program (e.g., additional staffing, safety concerns)? *

- ◯ Yes
- ◯ No

Has the child previously been required to leave a child care setting due to the program's inability to meet the child's needs? *

- ◯ Yes
- ◯ No
- ◯ Unsure

How often are there concerns about safety related to the child's participation and access to the classroom, including safety for themselves, their peers, or staff? *

Please Select

Please describe the challenges you are experiencing with the child in the program (e.g., what is happening, how often, etc.). *

Is the child currently able to self-regulate their behavior in a developmentally appropriate way (e.g., with adult support)? *

Please Select

What strategies has your program tried to put in place to address the child's safety, behavior, and/or health concerns? *

How long has the program been managing the challenges/trying strategies? *

Please Select

Child's Support Team

*Supports/Services may include:

- CIS Early Intervention
- CIS Family Support
- CIS Nurses
- CIS Child Care Coordinator
- CIS Early Childhood and Family Mental Health Consultant
- Early Childhood Special Education (formally EEE)
- School-Age Special Education
- Mental Health Services/Counseling
- Head Start/Early Head Start
- Children's Personal Care Services
- DCF – FSD
- Speech and Language Pathologist
- Occupational Therapists
- Deaf and Hard of Hearing Specialists
- Home Health Autism Consult
- Applied Behavior Analysis (ABA) Services
- Personal Care Assistance (PCA)
- UVM- ITeam

At this time, how often is there communication between your program and the child's support team (ex., service providers, family, community partners, public school) around the resources needed to support the child in care? *

Please Select

Child 2 Date of Birth *

Month Day Year

Child 2 Primary Physical Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Parent/Legal Guardian's Name *

First Name Last Name

Is the parent/legal guardian's primary physical address different than the child's? *

- Yes
- No

Phone Number *

Please enter a valid phone number.

Email *

example@example.com

Does this child/family have an open or custody case with the Family Services Division (FSD)? *

- Yes
- No

Does the child/family receive Child Care Financial Assistance? *

- Yes
- No

Does the child/family have health insurance? *

- Medicaid
- Private
- Both Medicaid and Private
- Uninsured

Has this child been supported previously by SAG funding in your program? *

- Yes
- No

Child's Schedule

Does the child have a current medical, developmental, or mental health condition? *

- ◯ Yes
- ◯ No
- ◯ Unsure

What strategies has your program tried to put in place to address the child's safety, behavior, and/or health concerns? *

How long has the program been managing the challenges/trying strategies? *

Please Select

*Supports/Services may include:

- CIS Early Intervention
- CIS Family Support
- CIS Nurses
- CIS Child Care Coordinator
- CIS Early Childhood and Family Mental Health Consultant
- Early Childhood Special Education (formally EEE)
- School-Age Special Education
- Mental Health Services/Counseling
- Head Start/Early Head Start
- Children's Personal Care Services
- DCF – FSD
- Speech and Language Pathologist
- Occupational Therapists
- Deaf and Hard of Hearing Specialists
- Home Health Autism Consult
- Applied Behavior Analysis (ABA) Services
- Personal Care Assistance (PCA)
- UVM- ITeam

Child 3

Child 3 Name *

First Name Last Name

Child 3 Primary Physical Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Is the parent/legal guardian's primary physical address different than the child's? *

- ◯ Yes
- ◯ No

Phone Number *

Please enter a valid phone number.

Does this child/family have an open or custody case with the Family Services Division (FSD)? *

- ◯ Yes
- ◯ No

Does the child/family receive Child Care Financial Assistance? *

- ◯ Yes
- ◯ No

Does the child/family have have insurance? *

- ◯ Medicaid
- ◯ Private
- ◯ Both Medicaid and Private
- ◯ Uninsured

Has this child been supported previously by SAG funding in your program? *

- ◯ Yes
- ◯ No

Child's Schedule

Child's Support Team

*Supports/Services may include:

- CIS Early Intervention
- CIS Family Support
- CIS Nurses
- CIS Child Care Coordinator
- CIS Early Childhood and Family Mental Health Consultant
- Early Childhood Special Education (formally EEE)
- School-Age Special Education
- Mental Health Services/Counseling
- Head Start/Early Head Start
- Children's Personal Care Services
- DCF – FSD
- Speech and Language Pathologist
- Occupational Therapists
- Deaf and Hard of Hearing Specialists
- Home Health Autism Consult
- Applied Behavior Analysis (ABA) Services
- Personal Care Assistance (PCA)
- UVM- ITeam

Please describe your engagement with rest of the child's support team? *

Please Select

Based on your ratings above, please describe how your engagement and communication with the child's team typically work. What factors influenced your ratings *

Child 4

Child 4 Name *

First Name Last Name

Child 4 Date of Birth *

Month Day Year

Child 4 Primary Physical Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Parent/Legal Guardian's Name *

First Name Last Name

Is the parent/legal guardian's primary physical address different than the child's? *

- Yes
- No

Phone Number *

Please enter a valid phone number.

Email *

example@example.com

Does this child/family have an open or custody case with the Family Services Division (FSD)? *

- Yes
- No

Does the child/family receive Child Care Financial Assistance? *

- ◯ Yes
- ◯ No

Does the child/family have health insurance? *

- ◯ Medicaid
- ◯ Private
- ◯ Both Medicaid and Private
- ◯ Uninsured

Has this child been supported previously by SAG funding in your program? *

- ◯ Yes
- ◯ No

Child's Schedule

Is this child currently attending your program? *

- ◯ Yes
- ◯ No, unable to access without additional supports

Learning About the Child

Has the child's medical, behavioral, and/or developmental needs impacted the child's placement within your program (e.g., additional staffing, safety concerns)? *

- ◯ Yes
- ◯ No

Has the child previously been required to leave a child care setting due to the program's inability to meet the child's needs? *

- ◯ Yes
- ◯ No
- ◯ Unsure

How often are there concerns about safety related to the child's participation and access to the

classroom, including safety for themselves, their peers, or staff? *

Please Select

Describe the challenges you are experiencing with the child in the program (e.g., what is happening, how often, etc.). *

Is the child currently able to form developmentally appropriate relationships with adults? *

Please Select

Is the child currently able to self-regulate their behavior in a developmentally appropriate way (e.g., with adult support)? *

Please Select

What strategies has your program tried to put in place to address the child's safety, behavior, and/or health concerns? *

How long has the program been managing the challenges/trying strategies? *

Please Select

Child's Support Team

*Supports/Services may include:

- CIS Early Intervention
- CIS Family Support
- CIS Nurses
- CIS Child Care Coordinator
- CIS Early Childhood and Family Mental Health Consultant
- Early Childhood Special Education (formally EEE)
- School-Age Special Education
- Mental Health Services/Counseling
- Head Start/Early Head Start

- Children's Personal Care Services
- DCF – FSD
- Speech and Language Pathologist
- Occupational Therapists
- Deaf and Hard of Hearing Specialists
- Home Health Autism Consult
- Applied Behavior Analysis (ABA) Services
- Personal Care Assistance (PCA)
- UVM- ITeam

Does your business or organization have a system in place that will account for 100% of each employee's time, including 100% of each employee's time associated with this award? *

Please Select

Job Title (Person Signing Above) *

Email *

example@example.com

Age of Child *

If the child is three years of age or older is the child receiving services from their Local Education Agency (LEA) e.g. School District or Supervisory Union? *

- ◯ Yes
- ◯ No

Name of LEA *

Town LEA is Located *

Does the child receive Universal Pre-K (UPK) funding (for 10 hours a week) in your program? *

- ◯ Yes
- ◯ No

Learning About The Child

Please enter the number of hours the child currently attends your program. IMPORTANT: All fields

must be filled. Enter zeros as needed.

	Monday hours	Tuesday hours	Wednesday hours	Thursday hours	Friday hours
Early Childhood					
Education Program					
Afterschool Program					

Total # of Hours

Please upload the Service/Health Provider Letter of Support if it was not submitted by the provider through the JotForm process .

Is the child currently able to form developmentally appropriate relationships with adults? *

Please Select

Please describe your engagement with the child's parent/guardian? *

Please Select

Please describe your engagement with rest of the child's support team? *

Please Select

Based on your ratings above, please describe how your engagement and communication with the identified child's team typically works. What factors influenced your ratings *

Age of Child

If the child is three years of age or older is the child receiving services from their Local Education Agency (LEA) e.g. School District or Supervisory Union?

- ◯ yes
- ◯ no

Name of LEA

Town LEA is Located

Does the child receive Universal Pre-K (UPK) funding (for 10 hours a week) in your program?

- ◯ Yes
- ◯ No

Learning About the Child

Is this child currently attending your program? *

- ◯ Yes
- ◯ No - Unable to access without additional supports.

Please enter the number of hours the child currently attends your program. IMPORTANT: All fields must be filled. Enter zeros as needed.

	Monday hours	Tuesday hours	Wednesday hours	Thursday hours	Friday hours
Early Childhood Education Program					
Afterschool Program					

Total # of Hours

Learning About the Child

Please upload the Service/Health Provider Letter of Support if it was not submitted by the provider through the JotForm process .

Child's Support Team

At this time, how often is there communication between your program and the child's support team (ex., service providers, family, community partners, public school) around the resources needed to support the child in care? *

Please Select

Email *

example@example.com

If the child is three years of age or older is the child receiving services from their Local Education Agency (LEA) e.g. School District or Supervisory Union?

- ◯ Yes
- ◯ No

Name of LEA

Town LEA is Located

Does the child receive Universal Pre-K (UPK) funding (for 10 hours a week) in your program? *

- ◯ Yes
- ◯ No

Learning About the Child

Is this child currently attending your program? *

- ◯ Yes
- ◯ No - Unable to access without additional supports.

Please enter the number of hours the child currently attends your program. IMPORTANT: All fields must be filled. Enter zeros as needed.

	Monday hours	Tuesday hours	Wednesday hours	Thursday hours?	Friday hours
Early Childhood Education Program					
Afterschool Program					

Total # of Hours

Please upload the Service/Health Provider Letter of Support if it was not submitted by the provider through the JotForm process .

At this time, how often is there communication between your program and the child's support team (ex., service providers, family, community partners, public school) around the resources needed to support the child in care? *

Please Select

If the child is three years of age or older is the child receiving services from their Local Education Agency (LEA) e.g. School District or Supervisory Union?

- ◯ Yes
- ◯ No

Name of LEA

Town LEA is Located

Does the child receive Universal Pre-K (UPK) funding (for 10 hours a week) in your program? *

- ◯ Yes
- ◯ No

Learning About the Child

Please enter the number of hours the child currently attends your program. IMPORTANT: All fields must be filled. Enter zeros as needed.

	Monday hours	Tuesday hours	Wednesday hours	Thursday hours?	Friday hours
Early Childhood Education Program					
Afterschool Program					

Total # of Hours

Please upload the Service/Health Provider Letter of Support if it was not submitted by the provider through the JotForm process .

Is the child currently able to engage in developmentally appropriate relationships with peers? *

Please Select

Does your program also have an active SAMS Registration? Please see SAM.gov for information on the difference between a UEI and an active registration. *

- ◯ Yes
- ◯ No
- ◯ In process

Did your business or organization have one or more audit findings in your last single audit regarding program non-compliance? A single audit is an organization-wide financial statement and federal awards' audit of a non-federal entity that expends $750,000.00 or more in federal funds in one fiscal year. *

- ◯ Yes
- ◯ No
- ◯ Not Applicable—my business or organization did not meet the federal funding threshold for a single audit during any of the last three fiscal years and therefore has not had a single audit in the last three fiscal years.

Child 2 Name *

Last Name

First Name

Exceptions to the Standard State Granting/Contracting Provisions

Name *

First Name Last Name

Child & Family Information

Address of Signature Signing Above: *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Has the child's medical, behavioral, and/or developmental needs impacted the child's placement within your program (e.g., additional staffing, safety concerns)? *

- Yes
- No

How often are there concerns about safety related to the child's participation and access to the classroom, including safety for themselves, their peers, or staff? *

Please Select

Is the child currently able to engage in developmentally appropriate relationships with peers? *

Please Select

Child 2

Is the child currently able to form developmentally appropriate relationships with adults? *

Please Select

Please describe your engagement with the child's parent/guardian? *

Please Select

Age of Child *

How often are there concerns about safety related to the child's participation and access to the classroom, including safety for themselves, their peers, or staff? *

Please Select

Is the child currently able to form developmentally appropriate relationships with adults? *

Please Select

Child & Family Information

Is the child currently able to engage in developmentally appropriate relationships with peers? *

Please Select

At this time, how often is there communication between your program and the child's support team (ex., service providers, family, community partners, public school) around the resources needed to support the child in care? *

Please Select

Please describe your engagement with the child's parent/guardian? *

Please Select

Based on your ratings above, please describe how your engagement and communication with the identified child's team typically works. What factors influenced your ratings *

Equipment/Materials
Specifications: Equipment and materials should directly support the inclusion and development of children with identified needs. The following categories outline acceptable use of grant requests up to $500.00 per application. The equipment and /or must remain in the child care program after the grant period ends to support overall inclusion of children with identified needs.

Please estimate indirect costs (costs associated with supporting the organization that may not directly relate to service delivery [your organization's accountant or IT security provisions are good examples.] Indirect costs may not exceed 10% of modified total direct project costs (this rate will increase to 15% for grants beginning October 1, 2024 or later) unless the organization has a federally approved indirect cost rate letter indicating a different rate. Enter 0 if not requesting an indirect cost *

*If you are using a federally approved indirect cost rate, please submit a copy of the letter with your application.

Does your program have a SAM Unique Entity ID (UEI)? *

- ◯ Yes
- ◯ No

Risk Assessment

Are any exceptions to the Standard State Granting/Contracting Provisions (noted on page 15 - State and Agency Customary Contracting Provisions of the RFGA) being proposed? *

Please Select

The Certificate of Insurance must include the following minimum coverages:

- Workers Compensation
- General Liability and Property Damage
    - The policy shall be on an occurrence form, and limits shall not be less than:
        - $1,000,000 Each Occurrence
        - $2,000,000 General Aggregate
        - $1,000,000 Products/Completed Operations Aggregate
        - $1,000,000 Personal & Advertising Injury
- Must have the State of Vermont listed as the Certificate Holder with the following address:
  State of Vermont, 280 State Drive, Waterbury, VT

05671

- The State of Vermont and its agencies, departments, officers, and employees listed as additional insureds for general liability must be included.

Certification & Submission

Has the child previously been required to leave a child care setting due to the program's inability to meet the child's needs? *

- ◯ Yes
- ◯ No
- ◯ Unsure

Is the child currently able to self-regulate their behavior in a developmentally appropriate way (e.g., with adult support)? *

Please Select

Please describe your engagement with rest of the child's support team? *

Please Select

Parent/Legal Guardian's Name *

First Name Last Name

Has the child previously been required to leave a child care setting due to the program's inability to meet the child's needs? *

- ◯ Yes
- ◯ No
- ◯ Unsure

Please describe your engagement with rest of the child's support team? *

Please Select

Funding Request Details

Please provide one funding request for all the identified children in your program

Fringe benefits cost for inclusion support staff: (allowances and services provided by employers to their employees as compensation in addition to regular salaries/wages. Fringe benefits include, but are not limited to, the costs of leave [vacation, family-related, sick or military], employee [illegible]nd unemployment benefit plans.) Enter 0 if not requesting fringe *

What type of accounting system do you use for your business/organization? *

Please Select

Required -W-9 Form

Please describe the challenges you are experiencing with the child in the program (e.g., what is happening, how often, etc.). *

Child 3 Date of Birth *

Month Day Year

Learning About the Child

Has the child's medical, behavioral, and/or developmental needs impacted the child's placement within your program (e.g., additional staffing, safety concerns)? *

- Yes
- No

Is the child currently able to self-regulate their behavior in a developmentally appropriate way (e.g., with adult support)? *

Please Select

Please describe your engagement with the child's parent/guardian? *

Please Select

By submitting this application, you certify to the following:

- The information provided on this application is true and accurate.
- I understand that the information provided on this application may be verified by other programs, such as Child Care Licensing, Child Care Financial Assistance Program and AHS prior to a grant award being issued.
- I agree that, as the Applicant, I must repay the grant or portion of the grant to the CDD if any grant funds received are based on incorrect representations made on this application or to the State related to this application.

Child & Family Information

Does the child have a current medical, developmental, or mental health condition or diagnosis? *

- ◯ Yes
- ◯ No
- ◯ Unsure

Age of Child *

SAM.Gov Information

Does your business or organization have an accounting system that allows you to completely and accurately track the receipt and disbursements of funds related to this grant award? *

Please Select

Based on your ratings above, please describe how your engagement and communication with the child's team typically work. What factors influenced your ratings *

What strategies has your program tried to put in place to address the child's safety, behavior, and/or health concerns? *

Does your business or organization maintain policies which include procedures for assuring compliance with the terms of grant and contract awards? *

Please Select

Please describe the challenges you are experiencing with the child in the program (e.g., what is happening, how often, etc.). *

How long has the program been managing the challenges/trying strategies? *

Please Select

Does the child have a current medical, developmental, or mental health condition or diagnosis? *

- ◯ Yes
- ◯ No
- ◯ Unsure

Additional Requirements

Did your business or organization have one or more audit findings in your last single audit regarding significant internal control deficiency? *

- ◯ Yes
- ◯ No
- ◯ Not Applicable—my business or organization did not meet the federal funding threshold for a single audit during any of the last three fiscal years and therefore has not had a single audit in the last three fiscal years.

Is the child currently able to engage in developmentally appropriate relationships with peers? *

Please Select

Required- Certificate of Insurance

Please submit a correct copy that meets the specifications below:

What type of SAG funding are you applying for? (Please select all that apply.) *

- ☐ Adaptive Equipment or Materials
- ☐ Specialized Training/Consultation and Coaching
- ☐ Inclusion Support Staff