



Operational Relief Grants for Child Care, Summer Day Camps & Afterschool Programs

Review

Program and Contact Information

[EDIT](#)

Program Name (from your license certificate if you have one)

Federal Business Name (from your license certificate or business income tax)

Mailing Address (PO Box or Street Address)

City / Town

State

Zip Code

City / Town where program is located

First Name

Phone

Email

Program Opening

Other Funding Sources

[EDIT](#)

Other Funding Sources

Name of Program	Other	Amount Received	Amount Anticipated
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Incurring and Anticipated Income Losses Due to COVID-19

[EDIT](#)

April 2020

May 2020

June 2020

July 2020

August 2020

September 2020

October 2020

Upload

Summary Total Income Losses Due to COVID-19

Total Income Losses Incurred

Total Income Losses Anticipated

Incurred Expenses Related to COVID-19

[EDIT](#)

March 2020

April 2020

May 2020

June 2020

July 2020

Upload

Stowe Vet Clinic.pdf

Anticipated Expenses Related to COVID-19 (cont.)

[EDIT](#)

August 2020

September 2020

October 2020

Summary Total Expenses Due to COVID-19

Total Expenses Incurred

Total Expenses Anticipated

Incurred Expenses Related to Structural Change

[EDIT](#)

Do you have any claims for incurred expenses for structural changes needed to meet Vermont Department of Health guidance?

Incurred Expenses Related to Structural

Changes (cont.)

[EDIT](#)

Explain the necessity of this expense compared to a non-structural alternative.

How much did you claim for making this structural change?

Anticipated Expenses Related to Structural Changes

[EDIT](#)

Do you have any claims for anticipated expenses for structural changes needed to meet Vermont Department of Health guidance?

Anticipated Expenses Related to Structural Changes (cont.)

[EDIT](#)

Information About Structural Changes

Explanation	Anticipated cost	File Upload
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Warning

After you click on “Submit” your application is considered complete.

You will not be able to edit it.

You may not submit another application.

Certification

By checking the boxes and typing my full name below, I certify that:

- All information in this application is true, correct, and complete to the best of my knowledge, I am duly authorized to submit this application on behalf of the provider, all content included in this document is subject to an audit, and I will produce documentation to support claims within thirty (30) days of any written request from the State. *

Your Full Name *

< PREVIOUS

SUBMIT >