DEPARTMENT OF CHIDREN AND FAMILIES
Division of Management Services

DCF Grant Award Application

Use of form: Use of this form is mandatory. If the requested information is not provided, the department will be unable to process your application. Personal information you provide may be used for secondary purposes [Privacy Law, §.15.04(1)(m), Wisconsin Statutes].

Application Number	Title
437002-G26-0002576	Head Start State Supplement Grant

Description of Services
Quality improvement efforts and/or expand Early/Head Start enrollment

Eligible Applicants
Authorized WI Head Start Agencies
More info at DPI Head Start Supplemental Grant Site

Issue Date	Due Date
5/7/2025	6/27/2025

DCF Contact Name	DCF Contact Phone
Abigail Widick	920-785-7844

DCF Contact Email
DCFHSSS@wisconsin.gov

Grantees will be expected to sign a contract. Most will be signing the DCF Standard Contract. For situations where the Standard Contract is not required, the DOA Standard Terms and Conditions will apply. Some awarded applicants may be asked to establish their financial stability. Samples of all can be found on our DCF Grant Opportunities Page.
https://dcf.wisconsin.gov/doingbusinesswith/applications

APPLICANT INFORMATION

Legal Applicant/Organization Name	Telephone Number

Applicant Contact Name	UEI

Applicant/Organization Mailing Address (Street, City, State, Zip Code)

Applicant Contact Email Address

We certify that everything in the application is true to the best of our knowledge and we will adhere to the requirements of the application and the resulting contract.

Authorized Company Representative Name	Company Representative Phone

Company Representative Title

Company Representative Email

Signature of Company Representative	Date Signed

Wisconsin Department of Children and Families

Wisconsin Department of Children and Families
APPLICATION—WISCONSIN HEAD START PROGRAM STATE SUPPLEMENT – 2025-2026
(Rev. 03-25)

INSTRUCTIONS:
See the DPI **Head Start State Supplement** website for **application due date.**

Email electronic application to**:**
DCFHSSS@wisconsin.gov

Collection of this information is a requirement of s.115.3615, Stats.

I. GENERAL INFORMATION

1. Applicant or Agency *Legal Name*	2. Mailing Address *Street, City, State, ZIP*	
3. Executive Director of Agency	3a.Telephone *Area/No.*	3b. Email Address
4. Head Start Director *If different from agency director*	4a.Telephone *Area/No.*	4b. Email Address
5. Agency Fiscal Contact	5a. Telephone *Area/No.*	5b. Email Address
6. Mailing Address *Street, City, State, ZIP*		

7a. Total **State** Entitlement Dollars Allowed	7b. Amount of **State** Funding Requested
8a. Number of **3-5 Year Old** Children Served with ***State*** Funds *If applicable*	8b. ***State*** Funding per **3-5 Year Old** Child
9a. Number of **Birth-to-3** Children Served with ***State*** Funds *If applicable*	9b. ***State*** Funding per **Birth-to-3** Child
10a. Number of **3-5 Year Old** Children Served with ***Federal*** Funds	10b. ***Federal*** Funding per **3-5 Year Old** Child
11a. Number of **Birth-to-3** Children Served with ***Federal*** Funds	11b. ***Federal*** Funding per **Birth-to-3** Child
12. Total **Federal** Funding as of June 1, 2025	

II. CERTIFICATION SIGNATURE

I, THE UNDERSIGNED, CERTIFY that the information contained in this application is complete and accurate to the best of my knowledge; that the necessary assurances of compliance with applicable state and federal statutes, rules, and regulations will be met; that I am authorized by the agency designated in this application to bind the agency to the certifications and assurances contained in this application; and, that the indicated agency designated in this application is authorized to administer this grant.

I FURTHER CERTIFY that the assurances listed on the next page have been satisfied and that all facts, figures, and representation in this application are correct to the best of my knowledge.

Name of Applicant Agency Authorizer *First and Last Name*	Title of Applicant Agency Authorizer

Signature of Applicant Agency Authorizer or Granting Authority	Date Signed *Mo./Day/Yr.*
➢	

Signatory Contact (person responsible for signing the contract in docuSign):

Signatory name, title

Phone number

Email

Contract Supplier Administrator (individual who will be managing the contract)

Name

Email

Contract CC (individuals receiving copy of contract)

Name

Email

Name

Email

Name

Email

III. ASSURANCES

The Applicant understands and agrees that the following assurances are pre-award requirements generally imposed by state law or regulation, and do not include all state regulations that may apply to the Applicant or its project.

Each Applicant is ultimately responsible for compliance with the certifications and assurances selected on its behalf that apply to its project or award.

Instructions

Step 1—**Read each assurance that follows and *Verify that all assurances have been met by initialing each assurance below:***

Step 2—Sign and date the certification statement on page 1

Step 3—Include signed certification and assurances with the application materials.

Step 4—Keep a copy for your records.

_____ 1. The applicant assures that these expenditures supplement but do not supplant federal or local funds expended for the same activities in the preceding fiscal year.

_____ 2. According to s.115.3615, Head Start State Supplement grantees must be designated Federal Head Start grantees. Therefore, Head Start State Supplement grantees are required to report to DCF any voluntary, required, current, or pending loss of their federal Head Start grantee status. This notice must be submitted to DCF no later than 10 days after the receipt of notification from the federal or regional Head Start office. In order to comply with s. 115.3615, if a Head Start grantee loses their federal grantee status, they will lose their status as a WI Head Start State Supplement grantee. In the event that federal grantee designation changes during the funded state program year, the grantee will be reimbursed for any valid state budget claim incurred during the period of their operation as a federal/state grantee. All unexpended funds (whether encumbered or not) will need to be returned.

_____ 3. The applicant will file financial reports and claims for reimbursement on a quarterly basis in accordance with procedures prescribed by the DCF.

_____ 4. The applicant will claim percent of the state supplement for federal grant in kind. (Include a number between 0-80.) No more than 80 percent of this state application can be used.

_____ 5. The Head Start grant recipient will either, provide data on children supported by the state supplement in their federal Program Information Report; and/or they have it available to provide it upon request.

_____ 6. A copy of the current ACF/HHS Notice of Financial Award approval for our federal grant application is attached. **Do not submit your entire federal application.**

_____ 7. In connection with performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of race, sex, religion, age, color, national origin, or handicapping condition. The aforesaid provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The contractor agrees to post notices where they are readily available to employees and employment applicants. The notices are to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause. Furthermore, the State of Wisconsin, Department of Children and Families operates under an Affirmative Action Plan and under a merit employment system.

_____ 8. The applicant will provide equal opportunities for individuals to participate in the project experiences in school and community settings regardless of age, sex, ethnic background, or disadvantaged, handicapped, or gifted status.

_____ 9. No advances are available through this funding.

_____ 10. The applicant assures that a single audit for the organization was submitted to the Audit Clearing House, if no audit was submitted, submit an electronic version of the audit and management letter. The financial audit summary and it's findings may be reviewed by DCF.

_____ 11. The applicant has included an electronic copy of their most recently approved program schedule for all grants, including additional detail on Head Start State Supplement children. Supplement Program Schedule Example.

_____ 12. All State Supplement children receive programming that meets all Head Start Program Performance Standards.

13. The applicant assures that, they will provide requested information if chosen for random review of invoices.

IV. ENTITLEMENT SECTION

1. Submit your most recent approved federal program schedule spreadsheet from HSES as of for all grants and add detail on state supplement children where needed/not already reflected in program schedule. See example on the DPI Head Start State Supplement page. *Check all that apply*.

   ☐ All State Head Start Supplement children are counted in federal program schedule.

   ☐ All State Early Head Start Supplement children are counted in federal program schedule.

   ☐ Any State Head Start Supplement children not counted in federal program schedule are added to the program schedule.. (See Supplement Program Schedule: Example on DPI Head Start State Supplement Website)

   ☐ Any State Early Head Start Supplement children not counted in federal program schedule are added to the program schedule. (See Supplement Program Schedule: Example on DPI Head Start State Supplement Website)

   ☐ Funds are being used for quality improvement activities.

2. If your supplement grant supports classroom slots, home visits or both, what is the placement of state supplement child? *Check all that apply*.

   ☐ State funded children are placed in classes with federally funded children.

   ☐ State funded children are placed in classes only with state funded children.

   ☐ State funded children are served in a home-based model.

   ☐ Not Applicable-NA

3. Do you contract with one or more school districts/local education authorities to offer 4K (i.e., are you a 4K Community Approach (4KCA) site)?

   ☐ No ☐ Yes *If "yes" please answer the below questions for each district.*

District/s which you contract with for 4K.	Does your program offer 4K hours separate from your Head Start hours?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No
4.	☐ Yes ☐ No
5.	☐ Yes ☐ No
6.	☐ Yes ☐ No
7.	☐ Yes ☐ No
8.	☐ Yes ☐ No
9.	☐ Yes ☐ No
10.	☐ Yes ☐ No

V. BUDGET DETAIL

Date of Request *Mo./Day/Yr.*	Applicant Agency	Project No. For revisions only

1. Personnel Summary

All staff must hold the appropriate license.

List all employees to be paid from this project. Do not include contracted personnel employed by other agencies in this section. If a vacancy exists which will be filled, indicate "vacant".

a. WUFAR Function Code **Only Required for LEAs** *Indicate for each position listed*	b. Name	c. Position/Title	d. Project FTE	e. Date(s) Service to be Provided (mm/dd/yy)	f. Total Cost Salary	Fringe
				Total Salary and Fringe *All project totals must equal salary and fringe totals on budget summary page.*	$ 0.00	$ 0.00

V. BUDGET DETAIL (cont'd)

V. BUDGET DETAIL (cont'd)

Date of Request *Mo./Day/Yr.*	Applicant Agency	Project No. *For revisions only*

2. Purchased Services Summary—Includes all items with Purchased Services Classification (e.g., staff professional development/training, cost for substitutes, consultant, internet/virtual connection supports, travel, postage, printing, phone.)

a. Type of Service Purchased	b. Date(s) Service to be Provided	c. Specify Agency/Vendor or Supplier *If known*	d. Cost
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		Total *Must agree with Purchase Services Total on Budget Summary*	$ 0.00

3. Non-Capital Objects Summary—Includes items which are expendable or consumed in one year (e.g., emergency health/well-being supplies, enrichment materials/packages for in-home engagement, materials, supplies, media, equipment).

a. Item Name *Include all items budgeted*	b. Quantity	c. Total Costs
	Total Must agree with Non-Capital Objects total on Budget Summary	0.00

V. BUDGET DETAIL (cont'd)

Date of Request *Mo./Day/Yr.*	Applicant Agency	Project No. *For revisions only*

4. Capital Objects Summary—Includes items of a permanent nature which are of significant value. Computers, iPads, furniture are supplies not capital expenditure under the Uniform Guidance. Modification for accessibility unless above agency's capitalization threshold would not be capitalized.

a. Item Name *Include all items budgeted*	b. Quantity	c. Total Costs
Total *Must agree with Capital Objects total on Budget Summary*		$ 0.00

5. **Other Objects Summary**—Items such as individualized professional development or extended programming that are not included in previous categories. Do not list indirect or administrative costs; these are not allowable.

a. Item Name *Include all items budgeted*	b. Quantity	c. Total Costs
Total *Must agree with Other Objects total on Budget Summary*		$ 0.00

V. BUDGET DETAIL (cont'd)

VI. SUMMARY OF BUDGET CATEGORIES

Totals must match budget detail on pages 4-6.

Applicant Agency	**Project Number** *For revisions only*	**Date Submitted**		
		Initial Request	First Revision	Second Revision

Budget Revisions: Submit a copy of this page, with appropriate revisions included. (Attach this to a brief letter of justification if additional space is needed beyond the revision rationale below.) **Note:** Submit request at least **30 days** prior to expenditure of grant monies.

Object Class Categories	**Initial Grant Request Entitlement**	**First Budget Revisions** *If needed.**	**Second Budget Revisions** *If needed**
1. Personnel	$ 0.00		
2. Purchased Services	$ 0.00		
3. Noncapital Objects	$ 0.00		
4. Capital Objects	$ 0.00		
5. Other Objects	$ 0.00		
6. Totals	$ 0.00	$ 0.00	$ 0.00

*To submit a revision REQUEST to this budget, complete the budget revision column above, describe your revision rationale below on page 9, and submit this form to DCFHSSS@wisconsin.gov **for approval**. Note that budget revision requests are required only when revisions exceed 10 percent of any budget line.

**REVISIONS MUST BE PRE-APPROVED PRIOR TO MAKING BUDGET CHANGES OR CLAIMS.

All REVISION REQUESTS FOR THE 2025-26 SUPPLEMENT GRANT ARE DUE BY APRIL 30, 2026 **

FOR DCF USE ONLY

Date of Review	Action Recommended ☐ Approve ☐ Modify ☐ Other *Specify*
Conditions	

Signature of DCF Head Start Collaboration Office Director

Date Signed Mo./Day/Yr

Revision Rationale Limit response to space provided.