



Illinois State Board of Education

100 North First Street, Springfield, Illinois 62777-0001

ATTACHMENT 1

Uniform Application for State Grant Assistance

Agency Completed Section		
1.	Type of Submission	<input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application
2.	Type of Application	<input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation (i.e. multiple year grant) <input type="checkbox"/> Revision (modification to initial application)
3.	Date/Time Received by State <i>Completed by State Agency upon Receipt of Application</i>	
4.	Name of the Awarding State Agency	Illinois State Board of Education
5.	Catalog of State Financial Assistance (CSFA) Number	586-18-2801
6.	CSFA Title	Federal Programs - CURE - After School Programs
Catalog of Federal Domestic Assistance (CFDA) <input type="checkbox"/> Not applicable (No federal funding)		
7.	CFDA Number	Coronavirus Urgent Remediation Emergency Fund
8.	CFDA Title	Coronavirus Urgent Remediation Emergency Fund
9.	CFDA Number	
10.	CFDA Title	
Funding Opportunity Information		
11.	Funding Opportunity Number	22-4998-AS
12.	Funding Opportunity Title	After School Programs - ARP - CURE
13.	Funding Opportunity Program Field	
Competition Identification <input checked="" type="checkbox"/> Not Applicable		
14.	Competition Identification Number	
15.	Competition Identification Title	

**Uniform Application for State Grant Assistance
Illinois State Board of Education**

Applicant Completed Section

APPLICANT NAME (District Name and Number, if applicable)		REGION COUNTY DISTRICT TYPE CODE
16.	Legal Name (Name used for DUNS registration and grantee prequalification)	
17.	Common Name (DBA)	
18.	Employer/Taxpayer Identification Number (EIN, TIN)	
19.	Organizational DUNS Number	
20.	SAM CAGE Code	
21.	Business Address (Street, City, State, County, Zip Code + 4)	
Applicant's Organizational Unit		
22.	Department Name	
23.	Division Name	
Applicant's Name and Contact Information for Person to be Contacted for <i>Program</i> Matters involving this Application		
24.	First/Last Name	
25.	Suffix	
26.	Title	
27.	Organizational Affiliation	
28.	Telephone Number (Include Area Code)	
29.	Fax Number (Include Area Code)	
30.	E-Mail Address	
Applicant's Name and Contact Information for Person to be Contacted for <i>Business/Administrative Office</i> Matters involving this Application		
31.	First/Last Name	
32.	Suffix	
33.	Title	
34.	Organizational Affiliation	
35.	Telephone Number (Include Area Code)	
36.	Fax Number (Include Area Code)	
37.	E-Mail Address	

**Uniform Application for State Grant Assistance
Illinois State Board of Education**

Applicant Completed Section (Continued)

Areas Affected

40.	Areas Affected by the Project (cities, counties, state-wide) <i>Add Attachments (e.g., maps), if needed</i>	
41.	Legislative and Congressional Districts of Applicant	
42.	Legislative and Congressional Districts of Program / Project <i>Attach an additional list, if needed</i>	

Applicant's Project

43.	Description Title of Applicant's Project <i>Text only for the title of the applicant's project.</i>	
44.	Proposed Project Term	Start Date: _____ End Date: _____
45.	Estimated Funding (Include all that apply)	<input type="checkbox"/> Amount Requested from the State: \$ _____ <input type="checkbox"/> Applicant Contribution (e.g., in kind, matching): \$ _____ <input type="checkbox"/> Local Contribution: \$ _____ <input type="checkbox"/> Other Source of Contribution: \$ _____ <input type="checkbox"/> Program Income: \$ _____ <div style="text-align: right;"><input type="checkbox"/> Total Amount: \$ _____</div>

Applicant Certification:

By signing this application, I certify (1) to the statements contained in the list of certifications* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil or administrative penalties. (U.S. Code, Title 18, Section 1001)

(*) The list of certification and assurances, or an internet site where you may obtain this list is contained in the Notice of Funding Opportunity.

☐ I agree

Authorized Representative

46.	First/Last	
47.	Suffix	
48.	Title	
49.	Telephone Number (Include Area Code)	
50.	Fax Number (Include Area Code)	
51.	E-Mail Address	
53.	Signature of Authorized Representative	
54.	Date Signed	



Illinois
State Board of
Education

Wellness Department
100 North First Street, E-222
Springfield, Illinois 62777-0001

ATTACHMENT 2

FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM SUMMARY

APPLICANT NAME	REGION, COUNTY, DISTRICT, TYPE CODE
A. PROPOSED NUMBER OF STUDENTS SERVED	B. LOCATION OF SERVICES
C. NUMBER OF WEEKS OF PROGRAMMING	
D. JOINT APPLICANT NAME	REGION, COUNTY, DISTRICT, TYPE CODE

Digital or Original Signature of
JOINT APPLICANT

Date



Illinois State Board of Education

Wellness Department
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ATTACHMENT 3A

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - NEED

Directions: Provide the information requested in the "Need" section of the RFP. *Responses must not exceed 4 pages.*



Illinois State Board of Education

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ATTACHMENT 3A

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - NEED

Directions: Provide the information requested in the "Need" section of the RFP. *Responses must not exceed 4 pages.*



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FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - NEED

Directions: Provide the information requested in the "Need" section of the RFP. *Responses must not exceed 4 pages.*



Illinois State Board of Education

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - NEED

Directions: Provide the information requested in the "Need" section of the RFP. *Responses must not exceed 4 pages.*



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ATTACHMENT 3B

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - EQUITY

Directions: Provide the information requested in the "Equity" section of the RFP. *Responses must not exceed 4 pages.*



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PROGRAM NARRATIVE - EQUITY

Directions: Provide the information requested in the "Equity" section of the RFP. *Responses must not exceed 4 pages.*



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PROGRAM NARRATIVE - EQUITY

Directions: Provide the information requested in the "Equity" section of the RFP. *Responses must not exceed 4 pages.*



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PROGRAM NARRATIVE - EQUITY

Directions: Provide the information requested in the "Equity" section of the RFP. *Responses must not exceed 4 pages.*



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ATTACHMENT 3C

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CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - PROGRAM DESIGN

Directions: Provide the information requested in the "Program Design" section of the RFP. *Responses must not exceed 4 pages.*



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CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - PROGRAM DESIGN

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROGRAM NARRATIVE - PROGRAM DESIGN

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ATTACHMENT 3C

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FY 2022
CURE AFTER SCHOOL
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PROGRAM NARRATIVE - PROGRAM DESIGN

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ATTACHMENT 3D

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PROGRAM NARRATIVE - CAPACITY

Directions: Provide the information requested in the "Capacity" section of the RFP. *Responses must not exceed 4 pages.*



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PROGRAM NARRATIVE - CAPACITY

Directions: Provide the information requested in the "Capacity" section of the RFP. *Responses must not exceed 4 pages.*



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PROGRAM NARRATIVE - CAPACITY

Directions: Provide the information requested in the "Capacity" section of the RFP. *Responses must not exceed 4 pages.*



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PROGRAM NARRATIVE - CAPACITY

Directions: Provide the information requested in the "Capacity" section of the RFP. *Responses must not exceed 4 pages.*



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ATTACHMENT 4

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

OBJECTIVES AND ACTIVITIES

APPLICANT NAME (Fiscal Agent) - LEA OR ENTITY NAME

REGION, COUNTY, DISTRICT, TYPE CODE

Directions: Provide the information requested in the Program Objectives section of the RFP. Detail what strategies will be used to meet each program objective. **Responses must not exceed 4 pages.**



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FY 2022
CURE AFTER SCHOOL
PROGRAMS

OBJECTIVES AND ACTIVITIES

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REGION, COUNTY, DISTRICT, TYPE CODE

Directions: Provide the information requested in the Program Objectives section of the RFP. Detail what strategies will be used to meet each program objective. ***Responses must not exceed 4 pages.***



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FY 2022
CURE AFTER SCHOOL
PROGRAMS

OBJECTIVES AND ACTIVITIES

APPLICANT NAME (Fiscal Agent) - LEA OR ENTITY NAME

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FY 2022
CURE AFTER SCHOOL
PROGRAMS

OBJECTIVES AND ACTIVITIES

APPLICANT NAME (Fiscal Agent) - LEA OR ENTITY NAME

REGION, COUNTY, DISTRICT, TYPE CODE

Directions: Provide the information requested in the Program Objectives section of the RFP. Detail what strategies will be used to meet each program objective. ***Responses must not exceed 4 pages.***



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ATTACHMENT 5

FY 2022
CURE AFTER SCHOOL
PROGRAMS

PROPOSAL EVALUATION DESIGN

APPLICANT NAME

REGION, COUNTY, DISTRICT, TYPE CODE

Instructions: Each proposal must include a detailed description of the methodology to be used and the data to be collected when determining the program's effectiveness, to include at least the data elements listed under the Evaluative Design Requirements of the RFP. ***Response limited to this page.***

☐ Initial Budget

☐ Amendment No. _____

☐ Revised Initial Budget

☐ Multi-district Application

ILLINOIS STATE BOARD OF EDUCATION
Wellness Department
100 North First Street, E-222
Springfield, Illinois 62777-0001

FY 2022

CURE AFTER SCHOOL PROGRAMS

FEDERAL BUDGET SUMMARY

Use whole dollars only. Omit Dollar Signs, Commas, and Decimal Places, e.g., 2536

ISBE USE ONLY

Please check:
☐ COMPLETED Notice of State Award (NOSA)
☐ COMPLETED Uniform Grant Agreement (UGA)

PROGRAM APPROVAL DATE AND INITIALS

TOTAL FUNDS

CARRYOVER FUNDS

CURRENT FUNDS

BEGIN DATE

END DATE

FISCAL YEAR 22	SOURCE OF FUNDS CODE	REGION, COUNTY, DISTRICT, TYPE CODE	SUBMISSION DATE (mm/dd/yyyy)
APPLICANT NAME (District Name and Number, if applicable)			
CONTACT PERSON		TELEPHONE NUMBER (Include Area Code)	
E-MAIL ADDRESS		FAX NUMBER (Include Area Code)	

LINE	FUNCTION NUMBER (1)	EXPENDITURE ACCOUNT (2)	SALARIES (3) (Obj. 100s)	EMPLOYEE BENEFITS (4) (Obj. 200s)	PURCHASED SERVICES (5) (Obj. 300s)	SUPPLIES AND MATERIALS (6) (Obj. 400s)	CAPITAL OUTLAY (7) (Obj. 500s)	OTHER OBJECTS (8) (Obj. 600s)	NON-CAPITALIZED EQUIPMENT (9) (Obj. 700s)	TOTAL (11)
1	1000	Instruction								
2	2110	Attendance & Social Work Services								
3	2120	Guidance Services								
4	2130	Health Services								
5	2140	Psychological Services								
6	2150	Speech Pathology & Audiology Services								
7	2210	Improvement of Instruction Services								
8	2220	Educational Media Services								
9	2230	Assessment & Testing								
10	2300	General Administration								
11	2400	School Administration								
12	2510	Direction of Business Support Services*								
13	2520	Fiscal Services*								
14	2530	Facilities Acquisition and Construction**								
15	2540	Operation & Maintenance of Plant Services								
16	2550	Pupil Transportation Services								
17	2560	Food Services								
18	2570	Internal Services*								
19	2610	Direction of Central Support Services								
20	2620	Planning, Research, Development & Evaluation Services								
21	2630	Information Services								
22	2640	Staff Services*								
23	2660	Data Processing Services*								
24	2900	Other Support Services								
25	3000	Community Services								
26	3700	Nonpublic School Pupil Services								
27	4000	Payments to Other Districts or Government Units								
28	5000	Debt Services								
29	Total Direct Costs									
30	Approved Indirect Costs x _____%*									
31	TOTAL BUDGET									

* Contact the GATA Department for indirect cost restrictions.

Date

Original Signature of Superintendent or Administrator

Date

Original Signature of ISBE Division Administrator

FUNCTION NUMBER (1)	EXPENDITURE DESCRIPTION AND ITEMIZATION (2)	SALARIES (3)	EMPLOYEE BENEFITS (4)	PURCHASES SERVICES (5)	SUPPLIES AND MATERIALS (6)	CAPITAL OUTLAY (7)	OTHER OBJECTS (8)	NON-CAPITALIZED EQUIPMENT (9)	TOTAL (11)
		(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)	(Obj. 600s)	(Obj. 700s)	
TOTAL									

FUNCTION NUMBER (1)	EXPENDITURE DESCRIPTION AND ITEMIZATION (2)	SALARIES (3)	EMPLOYEE BENEFITS (4)	PURCHASES SERVICES (5)	SUPPLIES AND MATERIALS (6)	CAPITAL OUTLAY (7)	OTHER OBJECTS (8)	NON-CAPITALIZED EQUIPMENT (9)	TOTAL (11)
		(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)	(Obj. 600s)	(Obj. 700s)	
TOTAL									

FUNCTION NUMBER (1)	EXPENDITURE DESCRIPTION AND ITEMIZATION (2)	SALARIES (3)	EMPLOYEE BENEFITS (4)	PURCHASES SERVICES (5)	SUPPLIES AND MATERIALS (6)	CAPITAL OUTLAY (7)	OTHER OBJECTS (8)	NON-CAPITALIZED EQUIPMENT (9)	TOTAL (11)
		(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)	(Obj. 600s)	(Obj. 700s)	
TOTAL									

FUNCTION NUMBER (1)	EXPENDITURE DESCRIPTION AND ITEMIZATION (2)	SALARIES (3)	EMPLOYEE BENEFITS (4)	PURCHASES SERVICES (5)	SUPPLIES AND MATERIALS (6)	CAPITAL OUTLAY (7)	OTHER OBJECTS (8)	NON-CAPITALIZED EQUIPMENT (9)	TOTAL (11)
		(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)	(Obj. 600s)	(Obj. 700s)	
TOTAL									

FUNCTION NUMBER (1)	EXPENDITURE DESCRIPTION AND ITEMIZATION (2)	SALARIES (3)	EMPLOYEE BENEFITS (4)	PURCHASES SERVICES (5)	SUPPLIES AND MATERIALS (6)	CAPITAL OUTLAY (7)	OTHER OBJECTS (8)	NON-CAPITALIZED EQUIPMENT (9)	TOTAL (11)
		(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)	(Obj. 600s)	(Obj. 700s)	
TOTAL									



Illinois
State Board of
Education

Wellness Department
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ATTACHMENT6B

FY 2022
CURE AFTER SCHOOL
PROGRAMS

BUDGET NARRATIVE

APPLICANT NAME (LEA)	REGION, COUNTY, DISTRICT, TYPE CODE
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INSTRUCTIONS: Provide a detailed narrative of the budget, its relevance to the number of students served, and how funds are focused on direct services to students. *Responses limited to 1 page.*