DIVISION OF ELEMENTARY & SECONDARY EDUCATION

Office of Early Childhood School Readiness Application

The **Early Childhood School Readiness Program** is administered by the Office of Early Childhood (OEC), to include Arkansas Better Chance (ABC) and Child Care Development Fund (CCDF). The purpose of the program is to increase the availability, affordability, and quality of childcare services for families in the state of Arkansas. Families who are eligible for assistance receive free or reduced childcare at approved state licensed providers (pending the availability of funds).

For information regarding Child Care services, Rights & Responsibilities and income guidelines, visit our website at: https://dese.ade.arkansas.gov/

For county resource information visit: https://humanservices.arkansas.gov/arworksresource/

IN ORDER TO PROCESS YOUR APPLICATION FOR OFFICE OF EARLY CHILDHOOD

For CCDF: Submit application and required documentation to oec.familysupport@ade.arkansas.gov

For ABC: Submit application and required documentation to a selected ABC Provider

APPLICATION:

- ☐ **Completed application**: All sections must be completed, and the application must be signed and dated. (***incomplete applications will be returned or denied***)
- ☐ **Declaration of asset question answered.**

DOCUMENTATION REQUIREMENTS:

- ☐ **Photo ID for all adults in the eligibility group:** driver's license, military, school, state issued, or passport
- ☐ **Photo ID for authorized representative (if applicable**): driver's license, military, school, state issued, or passport
- ☐ **Birth certificate for each child that services are requested**
- ☐ **Proof of citizenship for each child that services are requested**
- ☐ **Proof of Applicant's Residence (physical address):** may include but not limited to; lease contract, rent receipt, mortgage contract, bills, mail, state, or federal issued ID, check stubs, statement, or state systems verification.
- ☐ **Valid email address**
- ☐ **Social security number verification** for each household member (required for each child services are requested).
- ☐ **Immunization record/catch up schedule**
- ☐ **Well child screening/Physical**
- ☐ **Guardianship Documentation**

INCOME VERIFICATION (*must be provided for all household members within the family eligibility group*):

- ☐ **Earned income:** Supporting documents must include copies of consecutive check stubs for the last 30 days if applicable.
  - -If paid *weekly*, the last four (4) consecutive check stubs are required
  - -If paid *bi-weekly* (every two weeks), the last two (2) consecutive check stubs are required
  - -If paid *semi-monthly* (twice per month), the last two (2) consecutive check stubs are required
  - -If paid *monthly*, one (1) check stub for the last month is required, or
  - ▪ OEC Verification of Employment (VOE) form- completed by employer, or DCO-97 Verification of Earnings form- completed by employer,
  - ▪ Contract Agreement – A copy of the current contract between employee and employer
- ☐ **Self-employment earned income:** Documents to verify may include but are not limited to,
  - ▪ Last year's 1040 Tax Return with applicable schedule form (profit or loss from business); OR
  - ▪ DCC-575 Self-Employment Declaration form for last 30 days if applicable. (Only if self-employed for less than 1 year)

UNEARNED INCOME: Supporting documents must include verification for last 30 days (if applicable)

- ☐ **Supplemental Security Income (SSI)**
- ☐ **Social Security payments**
- ☐ **Workers Compensation**
- ☐ **Unemployment**
- ☐ **Alimony received for the last three (3) months**
- ☐ **Pensions, interest, and annuities**
- ☐ **Contributions**
- ☐ **Notarized statement of no earned income**

EDUCATION/JOB SKILLS TRAINING:

- ☐ **Class Schedule:** verification of enrollment, or written statement from advisor or institution on official letterhead
- ☐ **Job Skills training:** verification of enrollment, or written statement from advisor or institution on official letterhead
- ☐ **GED/Adult Education:** verification of enrollment, or written statement from advisor or institution on official letterhead

OTHER:

- ☐ **Child Care Arrangement Verification**

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All applicants must be eighteen (18) years and over or an emancipated minor. All applicants must have physical custody of the child(ren) for whom services are requested. If applying for Teen Parent, please enter Teen Parent's information below.

REQUIRED INFORMATION NEEDED FOR ALL PROGRAMS.

Parent or Guardian/Teen parent Information:

Social Security # (*Optional*)	First Name *(applicant)* MI Last Name	Date of Birth	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race (see codes):	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Primary Language:	Highest Level of Education or Training Completed:	Military Status (see codes):

# of Parents in home:	# in Family:	# of Household members:	Do you have household assets above $1,000,000? ☐Yes ☐No

Race Codes: **A** = Asian American **B** = Black/African American **H** = Hawaiian/Pacific Islander **I** = American Indian or Alaskan Native **W** = White/Caucasian **O** = Other

Military Status Codes: (Adults Only): N/A = No **AD** = Active Duty **NGMR** = National Guard/Military Reserve **VUSM=**Veteran of United States Military

Mailing Address	City/State	Zip	County	Home Phone/Cell:
Physical Address (if not the same)	**City/State**	**Zip**	**County**	**Message Phone:**

Current/Valid Email Address(required)

Second Parent or Guardian

Social Security # (*Optional*)	First Name MI Last Name	Date of Birth	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race (see codes):	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Primary Language:	Highest Level of Education or Training Completed:	Military Status (see codes):

Mailing Address	City/State	Zip	County	Home Phone/Cell:
Physical Address (if not the same)	**City/State**	**Zip**	**County**	**Message Phone:**

Have you ever received TEA or ESS? ☐ Yes ☐ No
Have the child(ren) transitioned from foster care? ☐ Yes ☐ No

Do you have an open protective service case? ☐ Yes ☐ No
Are you a Guardian or Custodian with physical custody? ☐ Yes ☐ No

Do you receive SNAP Benefits? ☐ Yes ☐ No
Are you currently receiving WIC? ☐ Yes ☐ No
Is any adult in household Disabled? ☐ Yes ☐ No

Current Housing: ☐Own ☐Rent ☐Homeless ☐Other
Current Housing Date:
Has your family moved in the past 24 months? ☐ Yes ☐ No

Check if applicable: ☐ Teen parent resides in the household.
☐ Teen parent is attending high school or GED program.
☐ Lacks regular, fixed, or adequate nighttime residence

☐ Shares housing due to economic hardship
☐ Lives in a shelter, hotel, or motel
☐ Lives in a place not designed for sleeping (cars, parks, etc.)

HOUSEHOLD INFORMATION: * A family's eligibility group is made up of one (1) or more adults and child(ren), who may or may not be, related by blood or law and residing in the same house when at least one of the adults has physical custody of the child(ren) for whom application is made. In households where adults other than spouses or parents of the child(ren) reside together, each may be considered a separate eligibility group. If requesting services each eligibility group must complete a separate application. List all information for household members included in the eligibility group.

Social Security #	First Name MI Last Name	Date of Birth:	Gender	Citizen/Legal Resident	Relationship to applicant:	Services Needed?	Race (see codes)	Military Status Adults only (see codes)
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		

EMPLOYMENT INFORMATION:

Name:	Employer:

Are you currently employed at a childcare facility who is a CCDF program participant? ☐Yes ☐No

Does your position with the program service birth to 5? ☐Yes ☐No

List work schedule below (List actual start/end times for each day) | **Working Status:** ☐Full Time ☐Part Time ☐Temporary ☐Seasonal

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Start Date:	Average Weekly Hours:	Estimated Daily Travel Time:

Name:	Employer:

Are you currently employed at a childcare facility who is a CCDF program participant? ☐Yes ☐No

Does your position with the program service birth to 5? ☐Yes ☐No

List work schedule below (List actual start/end times for each day) | **Working Status:** ☐Full Time ☐Part Time ☐Temporary ☐Seasonal

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Start Date:	Average Weekly Hours:	Estimated Daily Travel Time:

SCHOOL INFORMATION:

Name:	School:

☐ Currently attending GED program ☐ Currently attending high school ☐ Currently attending Higher Education or Job Skills Training Program

Start Date: End Date:	Hours Enrolled:	Student Status: ☐full time ☐part time	Major or course of study:

List school schedule below (List actual start/end times for each day) | **Estimated Daily Travel Time:**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Name:	School:

☐ Currently attending GED program ☐ Currently attending high school ☐ Currently attending Higher Education or Job Skills Training Program

Start Date: End Date:	Hours Enrolled:	Student Status: ☐full time ☐part time	Major or course of study:

List school schedule below (List actual start/end times for each day) | **Estimated Daily Travel Time:**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

HOUSEHOLD INCOME: Proof of ALL household income must be provided. List how often received; Weekly, Bi-Weekly, Twice Monthly, Monthly

Name of person(s) receiving:

Gross Wages		☐SSI ☐SSA		☐Commission ☐Bonus		Other: (Explain)	
Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often

Name of person receiving:

Gross Wages		☐SSI ☐SSA		☐Commission ☐Bonus		Other: (Explain)	
Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often

INFORMATION FOR CHILD(REN) SERVICES ARE REQUESTED

Child's Name	List any medical or developmental disabilities	Name of Child care Participant selected	List days and hours of care needed for the child	Child attends ABC, Head Start or Federal Pre-K	School child currently attends
				☐ Yes ☐ No	

Medical Insurance
ARKids #
Does child have any special dietary needs? ☐ Yes ☐ No
List any allergies (food, insects, etc.):

Has child attended a state-funded Pre-K (ABC) program? ☐ Yes ☐ No
If so, where?
Will child be concurrently enrolled in an ABC center and HIPPY or PAT program? ☐ Yes ☐ No
If so, which HIPPY or PAT Program?
Does child receive any special education services? ☐ Yes ☐ No

Child's Name	List any medical or developmental disabilities	Name of Child care Participant selected	List days and hours of care needed for the child	Child attends ABC, Head Start or Federal Pre-K	School child currently attends
				☐ Yes ☐ No	

Medical Insurance
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Does child receive any special education services? ☐ Yes ☐ No

Child's Name	List any medical or developmental disabilities	Name of Child care Participant selected	List days and hours of care needed for the child	Child attends ABC, Head Start or Federal Pre-K	School child currently attends
				☐ Yes ☐ No	

Medical Insurance
ARKids #
Does child have any special dietary needs? ☐ Yes ☐ No
List any allergies (food, insects, etc.):

Has child attended a state-funded Pre-K (ABC) program? ☐ Yes ☐ No
If so, where?
Will child be concurrently enrolled in an ABC center and HIPPY or PAT program? ☐ Yes ☐ No
If so, which HIPPY or PAT Program?
Does child receive any special education services? ☐ Yes ☐ No

Emergency Contact if parent/guardian cannot be reached:

Name:	Relationship:	Phone:	
Address:	City:	State:	Zip:
Physician Name:		Phone:	
Address:	City:	State:	Zip:

Consent for Emergency Medical Care:

I ____ ____________________________ of _______________________________________

Parent/Guardian's Name   Relationship   Child Name

Do hereby request and give consent to the Director/Caregiver of the Child Care Facility, or their duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessarily expedient by a duly licensed or recognized physician or surgeon in case of an emergency when parents cannot be reached. Consent is also given for the Director/Caregiver or their duly appointed representative, to transport said child for emergency medical treatment, if parent(s) cannot be reached.

_ ____ _ _______________________

Parent/Guardian Signature   **Date**

Authorized Representative (If applicable): If you want to choose someone to represent you, please complete the following information. If you name an authorized representative, this person will be able to talk to the case manager on your behalf.
(Photo ID required for authorized representative)
*****CCDF Program Participant (child care provider) CANNOT be listed as authorized representative*****

Name of Authorized Representative:	Home or Cell Phone #

***Applicant Certification:**

I certify under penalty of perjury and fraud that all information I have supplied is true and correct. I understand that giving false information or withholding information may result in denial, termination, or disqualification of services or criminal prosecution, and the repayment of financial assistance made on my behalf. I authorize OEC to collect information from other sources to determine my eligibility for services. I authorize any source OEC deems necessary to determine eligibility to release information concerning me. I certify that I have read and understand my Rights and Responsibilities, (available on the website).

Applicant Signature: __________________________ **Applicant Printed Name**: ____________________________ **Date**: __________

Teen Parent Signature: _________________________ **Teen Parent Printed Name**: _________________________ **Date**: __________

Official use only:
Program applying for? ☐Low Income ☐ESS ☐ABC ☐EHS ☐Federal Pre-K ☐ABC/ITS ☐ABC Summer ☐Other