



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 ocf.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)

- | | |
|---|--|
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Social Security payments |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Alimony received for the last three (3) months | <input type="checkbox"/> Pensions, interest, and annuities |
| <input type="checkbox"/> Contributions | <input type="checkbox"/> 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



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:

Form for Parent or Guardian/Teen parent information including Social Security #, First Name, MI, Last Name, Date of Birth, Gender, Marital Status, Race, Ethnicity, Primary Language, Highest Level of Education or Training Completed, Military Status, # of Parents in home, # in Family, # of Household members, and household assets.

Second Parent or Guardian

Form for Second Parent or Guardian information including Social Security #, First Name, MI, Last Name, Date of Birth, Gender, Marital Status, Race, Ethnicity, Primary Language, Highest Level of Education or Training Completed, Military Status, Mailing Address, Physical Address, and household information questions.

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.

Table with 11 columns: 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). It contains 6 rows for listing household members.

EMPLOYMENT INFORMATION:						
Name:			Employer:			
Are you currently employed at a childcare facility who is a CCDF program participant? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Does your position with the program service birth to 5? <input type="checkbox"/> Yes <input type="checkbox"/> No						
List work schedule below (List actual start/end times for each day)				Working Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Does your position with the program service birth to 5? <input type="checkbox"/> Yes <input type="checkbox"/> No						
List work schedule below (List actual start/end times for each day)				Working Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal		
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Date:		Average Weekly Hours:		Estimated Daily Travel Time:		

SCHOOL INFORMATION:						
Name:			School:			
<input type="checkbox"/> Currently attending GED program <input type="checkbox"/> Currently attending high school <input type="checkbox"/> Currently attending Higher Education or Job Skills Training Program						
Start Date:	End Date:	Hours Enrolled:	Student Status: <input type="checkbox"/> full time <input type="checkbox"/> 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:			
<input type="checkbox"/> Currently attending GED program <input type="checkbox"/> Currently attending high school <input type="checkbox"/> Currently attending Higher Education or Job Skills Training Program						
Start Date:	End Date:	Hours Enrolled:	Student Status: <input type="checkbox"/> full time <input type="checkbox"/> 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		<input type="checkbox"/> SSI <input type="checkbox"/> SSA		<input type="checkbox"/> Commission <input type="checkbox"/> Bonus		Other: (Explain)	
Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often
Name of person receiving:							
Gross Wages		<input type="checkbox"/> SSI <input type="checkbox"/> SSA		<input type="checkbox"/> Commission <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	School child currently attends
Medical Insurance ARKids # Does child have any special dietary needs? <input type="checkbox"/> Yes <input type="checkbox"/> No List any allergies (food, insects, etc.):		Has child attended a state-funded Pre-K (ABC) program? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where? Will child be concurrently enrolled in an ABC center and HIPPPY or PAT program? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which HIPPPY or PAT Program? Does child receive any special education services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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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
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