

The 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 School Readiness 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,
<ul> <li>Last year's 1040 Tax Return with applicable schedule form (profit or loss from business); OR</li> <li>DCC-575 Self-Employment Declaration form for last 30 days if applicable (Only if self-employed for less than 1 year)</li> </ul>
<u>UNEARNED INCOME:</u> 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:
School Readiness Arrangement Form



## **School Readiness Application**

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.

		RE	QUIRED IN	FORMAT	TION NEE	DEI	D FOR	ALL P	ROGRAMS.			
Parent or Guard	lian/Tee	n parent Info	rmation:									
Social Security # (Op	otional)	First Name (ap	pplicant) MI	Last Na	ame		Date of	Birth	Gender:  ☐ Male ☐ Female	•	ntus: ☐ <b>M</b> arried ☐ ed ☐ Widow	
Race (see codes):	Ethnicit	y: Hispanic or		Primary La	inguage:	_	nest Leve		ation or	Military St	atus (see code	s):
# of Parents in home	e:	# in Family:		# of House	hold membe	ers:		Do yo	u have household	assets above	e \$1,000,000?	□Yes □No
Race Codes: A = Asia Islander I = American			can American <b>H</b> : <b>W</b> = White/Cauca	•			•		(Adults Only): N/A rd/Military Reserve		•	ates Military
Mailing Address				City/State		Zip	C	ounty		Home Pho	ne/Cell:	
Physical Address (if	not the sa	ime)		City/State		Zip	С	ounty		Message P	hone:	
Current/Valid Email	Address(	required)				I						
Second Parent of	or Guard	lian										
Social Security # (Op	otional)	First Name	М	l L	ast Name		Date of	Birth	Gender:  ☐ Male	•	☐ <b>M</b> arried ☐	
Race (see codes):	Ethnicit	y:  Hispanic or Not Hispani		Primary La	inguage:		nest Leve ning Com		Female cation or	Military St	ed 🗆 Widow atus (see code	ea ·s):
Mailing Address	l			City/State		Zip	C	ounty		Home Pho	ne/Cell:	
Physical Address (if	not the sa	ime)		City/State		Zip	С	ounty		Message P	hone:	
Have you ever recei Have the child(ren)	transition	ed from foster c	are? 🗌 Yes 🗆	No			•	•	protective service or Custodian with			□ No
Do you receive SNA Are you currently re Is any adult in house	ceiving W	'IC? ☐ Yes ☐ I	No			Curi	rent Hous	ing Date	Own □Rent □I e: ed in the past 24 n			
Check if applicable	☐ Tee	n parent resides n parent is atten ks regular, fixed,	ding high school	or GED progi			Lives in a	shelte	due to economic r, hotel, or mote	l ·	ars parks of	c.)
HOUSEHOLD INFO blood or law and households when requesting service group.	ORMATIC residing e adults	ON: * A family in the same ho other than spo	's eligibility gr ouse when at lo ouses or parer	oup is made east one of onts of the c	de up of on the adults thild(ren) re	e (1) has p eside	or more physical togethe	adults custody er, each	y of the child(re may be consid	who may on the service of the servic	or may not b n application arate eligibil	e, related by n is made. In ity group. If the eligibility
Social Security #	First Na	me MI	Last Name	Date of Birth:	Gender		zen/Legal esident	Re	elationship to applicant:	Services Needed?	Race (see codes)	Military Status Adults only (see codes)
					☐ Male ☐ Female	□ Y				☐ Yes ☐ No		
					☐ Male	□ Y	es			☐ Yes		
					☐ Female ☐ Male	□ N				☐ No		
					Female					□ No		
					☐ Male ☐ Female	□ Y				☐ Yes ☐ No		
					☐ Male	□ Y				□ No		
					☐ Female					□ No		
					☐ Male ☐ Female	□ Y				☐ Yes ☐ No		

EMPLOYMENT I	NFORMATION:												
Name:						Employ	yer:						
Are you currently employed at a childcare facility who is a CCDF program particle.						□Yes □No							
Does your position	with the program se	rvice birth to 5	<b>5?</b> □Ye	s $\square$ No									
List work schedule b	elow (List actual sta	rt/end times f	for each	n day)		Working	g Statu	s: □Fu	ıll Time [	□Par	t Time □Temporar	у 🗆	Seasonal
Monday	Tuesday		Wedn	esday	Thur	sday		Friday	/		Saturday		Sunday
Start Date:			Avera	ge Weekly Ho	ours:				Estimate	ed Da	ily Travel Time:		
Name:						Employ	yer:						
Are you currently er	nployed at a childca	re facility who	is a CC	DF program p	articipant	P □Yes □I	No						
Does your position	with the program se	rvice birth to 5	<b>5?</b> □Ye	s $\square$ No									
List work schedule b	elow (List actual sta	rt/end times f	for each	n day)		Working	g Statu	s: □Fu	ıll Time [	□Par	t Time □Temporar	у 🗆	Seasonal
Monday	Tuesday		Wedn	esday	Thur	sday		Friday	/		Saturday		Sunday
Start Date:			Avera	ge Weekly Ho	ours:				Estimate	ed Da	ily Travel Time:		
SCHOOL INFORM	MATION:												
Name:			S	chool:									
$\square$ Currently atten	ding GED program	☐ Curr	ently a	ttending hig	h school	☐ Curr	ently a	attendir	ng Highe	r Edu	cation or Job Skill	s Trai	ning Program
Start Date:	End Date:	Hou	ırs Enro	lled:	Student S	Status: □fu	III time	□part t	ime	Majo	r or course of study:	:	
List school schedu	le below (List actu	ial start/end	times	for each day	/) Estin	nated Daily	Travel	Time:	<u>,                                    </u>				
Monday	Tuesday		Wedn	esday	Thu	ırsday		Fr	iday		Saturday		Sunday
Name:		<u> </u>	S	chool:			_						
☐ Currently atten	ding GED program	☐ Curre	ntly att	tending high	school	☐ Curr	ently a	attendir	ng Highe	r Edu	ıcation or Job Skill	s Trai	ning Program
Start Date:	End Date:	Hou	ırs Enro	lled:	Student	Status: 🗆 f	ull time	e □part	time	Majo	r or course of study:	:	
List school schedu	le below (List actu	ıal start/end	times	for each day	/) Estin	nated Daily	Travel	Time:					
Monday	Tuesday		Wedn	esday	Thu	ırsday		Fr	iday		Saturday		Sunday
HOUSEHOLD IN	COME: Proof of A	LL household	d incor	me must be i	provided.	List how	often	receive	d; Week	dy, Bi	i-Weekly, Twice N	/lonth	nly, Monthly
Name of person(s										•			
Gross V	Vages		]ssi	□SSA		Com	missio	n [	Bonus		Other: (Explain)		
Amount	How Often	Amount	t	How Oft	en	Amount	;	Ho	w Often		Amount		How Often
										+		+	
Name of person r	eceiving:												
Gross V		Г	]ssi	SSA		Com	missio	n [	Bonus		Other: (Explain)		
Amount	How Often	Amount		How Ofte	on								
				HOW OIL	en i	Amount	[	Ho	w Often		Amount		How Often

Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Child's Name  List any medical or developmental disabilities  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Does child receive any special education services?   Yes   No  Child's Name  List any medical or developmental disabilities  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No  List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No  List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child attended a state-funded Pre-K (ABC) program?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child attended a state-funded Pre-K (ABC) program?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child attended a state-funded Pre-K (ABC) program?   Yes   No List any allergies (food, insects, etc.):  Medical Insurance ARKids # Does child attended a state-funded Pre-K (ABC) program?   Yes   No List days and hours of   Child attends ABC   Child atten	INFORMATION FOR CHILD(I	REN) SERVICES ARE R	REQUESTED									
Medical insurance   Has child attended a state-funded Pre-K (ABC) program?   Ves   No   If so, where?   Will child be concurrently enrolled in an ABC center and HIPPY or PAT program?   Does child have any special dietary needs?   Ves   No   If so, which HIPPY or PAT program?   Does child receive any special education services?   Ves   No   If so, which HIPPY or PAT program?   Does child receive any special education services?   Ves   No   Child's Name   List any medical or developmental disabilities   Name of School Readiness   List days and hours of   Care needed for the child   C	Child's Name	•			-		C School child currently attends					
Medical Insurance   Mas Child attended a state-funded Pre-K (ABC) program?   Ves   No   If so, where?   Will child be concurrently enrolled in an ABC center and HIPPY or PAT program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   If so, which HIPPY or PAT Program?   Ves   No   Name of School Readiness   List days and hours of   Child attends ABC   Currently attend   Ves   No   Ves   No   If so, where?   Ves   No   Ves   No   If so, where?   Ves   No   If so, wher												
List any medical or developmental disabilities	ARKids # Does child have any special dietar	-	If so, where? Will child be concu	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?								
Medical Insurance   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?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT program?   Yes   No   If so, which HIPPY or PAT 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	Child's Name	List any modical or				T.	C School shild					
Medical Insurance   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   No   Name of School Readiness   Participant selected   Name of School Readiness   Name of School Rea	Ciliu's Name	•			-		currently attends					
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, 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   List any special education services?   Yes   No   Child attends ABC   School child receive any special education services?   Yes   No   The so   No   The		-										
List any medical or developmental disabilities	ARKids # Does child have any special dietar	=	If so, where? Will child be concu If so, which HIPPY	urrently en or PAT Pro	rolled in an ABC center and gram?	☐ Yes ☐ No HIPPY or PAT progra	m? □ 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 List any allergies (food, insects, etc.):   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   No   Emergency Contact if parent/guardian cannot be reached:   Name:   Relationship:   Phone:	Child's Name	List any medical or	Name of School Re	eadiness	List days and hours of	Child attends AB	C School child					
Medical Insurance ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):    Base		developmental disabiliti	ies Participant sele	ected	care needed for the child		currently attends					
ARKids # Does child have any special dietary needs?   Yes   No List any allergies (food, insects, etc.):   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    Relationship:   Phone:												
Name:  Relationship:  Phone:  Address:  City:  State:  Zip:  Physician Name:  Address:  City:  State:  Zip:  Consent for Emergency Medical Care:  I	ARKids # Does child have any special dietar	•	If so, where? Will child be concu If so, which HIPPY	urrently en or PAT Pro	rolled in an ABC center and gram?	HIPPY or PAT progra	m? □ Yes □ No					
Address:  City:  State:  Zip:  Physician Name:  Address:  City:  State:  Zip:  Consent for Emergency Medical Care:  I	<b>Emergency Contact if parer</b>	nt/guardian cannot b	e reached:									
Physician Name:  Address:  City:  State:  Zip:  Consent for Emergency Medical Care:  I	Name:		Relationship:			Phone:						
Address:  City:  State:  Zip:  Consent for Emergency Medical Care:  I	Address:		City:			State:	Zip:					
Consent for Emergency Medical Care:  I	Physician Name:	<u> </u>				Phone:	1					
I of of Parent/Guardian's Name Relationship Child Name  Do hereby request and give consent to the Director/Caregiver of the School Readiness 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	Address:		City:			State:	Zip:					
Parent/Guardian's Name Relationship Child Name Do hereby request and give consent to the Director/Caregiver of the School Readiness 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	Consent for Emergency Me	dical Care:										
cannot be reached.  Parent/Guardian Signature  Date	Parent/Guardian's Nam Do hereby request and give conse medical or surgical aid as may be reached. Consent is also given for	ent to the Director/Caregion deemed necessarily expec the Director/Caregiver or	ver of the School Reading dient by a duly licensed of their duly appointed re	ess Facility or recogniz	or their duly appointed re ed physician or surgeon in c	oresentative, for said ase of an emergenc or emergency medica	y when parents cannot be					
Authorized Representative (If applicable): If you want to choose someone to represent you, please complete the following information. If you name an authorize representative, this person will be able to talk to the case manager on your behalf. (Photo ID required for authorized representative)  ***CCDF Program Participant (School Readiness provider) CANNOT be listed as authorized representative***	representative, this person will be	able to talk to the case ma	anager on your behalf. (P	hoto ID re	quired for authorized repres	J	you name an authorized					
Name of Authorized Representative:  Home or Cell Phone #	Name of Authorized Represen	tative:		Home o	r 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 inform may result in denial, termination, or disqualification of services or criminal prosecution, and the repayment of financial assistance made on my behalf. I authorize 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).	I certify under penalty of perj may result in denial, terminat collect information from othe	tion, or disqualification of ser sources to determine my	services or criminal prose y eligibility for services. I	ecution, an authorize	d the repayment of financial any source OEC deems neces	assistance made on ssary to determine el	my behalf. I authorize OE					
Applicant Signature: Applicant Printed Name: Date:	Applicant Signature:		Applicant Printe	ed Name:	Da	Date:						
Teen Parent Signature: Teen Parent Printed Name: Date:	Teen Parent Signature: _		Teen Parent Pr	Teen Parent Printed Name:								