

The **Early Childhood Education and Out of School Time Program Assistance** is administered by the Family Support Unit of the Division of Childcare and Early Childhood Education. 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).

**IN ORDER TO PROCESS YOUR ESSENTIAL SERVICES WORKER CHILD CARE APPLICATION, THE FOLLOWING INFORMATION IS REQUIRED;**

**APPLICATION:**

- Completed application:** All sections must be completed, and application must be signed and dated.  
*(incomplete applications will be returned or denied)*

**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 assistance is requested**  
 **Social security number verification** for each household member (required for each child assistance is 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, notarized statement or state systems verification.  
 **Verification of essential employment:** most recent check stub received within the last 30 days, or employer statement on letterhead.  
 **Valid email address**

If you provide Essential Services in the category below and are over 85% of State Median Income, see chart below, **PLEASE** complete the attached application and email to [FamilySupport@dhs.arkansas.gov](mailto:FamilySupport@dhs.arkansas.gov). If you are below the income levels below, you may be eligible for our regular child care assistance program.

Emergency Responders  
Health Care Providers  
Manufacturing workers  
Sanitation workers

Education/Child Care personnel  
Public Health personnel  
Food Supply Chain personnel

**85% State Median Income (SMI)**

Family Size	Income Eligible	Over Income
2-Person Families	\$3,343.43	\$3,343.44
3-Person Families	\$4,130.12	\$4,130.13
4-Person Families	\$4,916.82	\$4,916.83
5-Person Families	\$5,703.51	\$5,703.52
6-Person Families	\$6,490.20	\$6,490.21
7-Person Families	\$6,637.70	\$6,637.71
8-Person Families	\$6,785.21	\$6,785.22
9-Person Families	\$6,932.71	\$6,932.72
10-Person Families	\$7,080.22	\$7,080.23
11-Person Families	\$7,227.72	\$7,227.73



**Early Childhood and Out of School Time Program Assistance  
Essential Service Worker Application  
Email Applications to: FamilySupport@dhs.arkansas.gov**

PARENT/GUARDIAN INFORMATION:									
Social Security # <i>(Optional)</i>		First Name MI Last Name <i>(applicant)</i>			Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Race (see codes):	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Primary Language:	#of Parents in home:	Household Size:	Highest Level of Education or Training Completed:			
Race Codes: A = Asian American B = Black/African American H = Hawaiian/Pacific Islander I = American Indian or Alaskan Native W = White/Caucasian O = Other									
Mailing Address		City/State			Zip	County	Home Phone/Cell:		
Street Address (if not the same)		City/State			Zip	County	Message Phone:		
Current/Valid Email Address (required)				Do you have assets in excess of \$1,000,000? <input type="checkbox"/> Yes <input type="checkbox"/> No		School District (No abbreviations):			
HOUSEHOLD INFORMATION: * A family's eligibility group is made up of one (1) or more adults who are working 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. 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 Parent/ Guardian	Child Care Needed	Race (see codes)
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you provide essential work in one of the areas below related to COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If Yes, check the areas that apply to you below:									
<input type="checkbox"/> Emergency Responders					<input type="checkbox"/> Public Health personnel				
<input type="checkbox"/> Health Care Providers					<input type="checkbox"/> Education/Child Care personnel				
<input type="checkbox"/> Manufacturing Workers					<input type="checkbox"/> Food Supply Chain personnel				
<input type="checkbox"/> Sanitation Workers									
Name of Employer: _____					Supervisor or Human Resources Contact: _____				
Phone Number: _____					Email Address: _____				
<u>Spouse Information (if applicable):</u>									
Name of Employer: _____					Supervisor or Human Resources Contact: _____				
Phone Number: _____					Email Address: _____				
<b>CERTIFICATION:</b> I certify that I am an Essential employee at my place of employment, which is providing essential services during the COVID-19 pandemic, and I do not have access to a safe and healthy alternative childcare option. I understand that Child Care Assistance may only be extended for the duration of the COVID-19 pandemic. I certify that all information provided is true and correct. I understand that giving false information or withholding information may result in denial, termination, or disqualification of Child Care Assistance or criminal prosecution, and the repayment of financial assistance made on my behalf.									
Applicant Signature					Applicant Signature Date				
Child Care Provider Information:									
Child Care Provider Signature					Child Care Provider Signature Date				
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3		
Child Care Provider License No.			Quality Approved?			Better Beginnings Level			