



better beginnings

BETTER BEGINNINGS APPLICATION
SCHOOL-AGE

FACILITY INFORMATION

NEW APPLICANT - APPLYING FOR LEVEL ① ② ③
 CERTIFIED - REQUESTING NEW LEVEL ① ② ③
 CERTIFIED- CHANGE IN LOCATION / OWNER (Circle one)
 CONTINUING CERTIFICATION - TERM EXPIRING on ____/____/____

FACILITY NAME:		FACILITY NUMBER:	
OWNER NAME:		OWNER PHONE:	
DIRECTOR NAME:		OWNER EMAIL:	
SITE ADDRESS:			
CITY:		ZIP CODE:	COUNTY:
MAILING ADDRESS: (IF DIFFERENT THAN SITE)			
CITY:		ZIP CODE:	COUNTY:
PHONE:		ALTERNATIVE CONTACT NAME:	
FAX:		SITE CONTACT EMAIL:	

OPERATION

DATES OF OPERATION:
 OPEN YEAR ROUND
 OPEN PART YEAR: FROM _____ TO: _____

FACILITY IS OPEN:
 20 HOURS OR FEWER PER WEEK
 40 HOURS OR FEWER PER WEEK
 MORE THAN 40 HOURS PER WEEK

HOURS OF OPERATION: MONDAY _____ to _____ TUESDAY _____ to _____ WEDNESDAY _____ to _____ THURSDAY _____ to _____ FRIDAY _____ to _____ SATURDAY _____ to _____ SUNDAY _____ to _____	SPECIFY SEASONAL HOUR VARIATIONS (E.G. SUMMER HOURS: 9-12 ONLY, FULL DAYS ON ALL SCHOOL HOLIDAYS, ETC.)
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FACILITY DEMOGRAPHICS

LICENSED CAPACITY: SCHOOL AGE: _____	NATIONAL ACCREDITATION ATTACH COPY OF ACCREDITATION CERTIFICATE <input type="checkbox"/> NAEYC <input type="checkbox"/> NAA <input type="checkbox"/> CARF <input type="checkbox"/> NAFCC
FACILITY PARTICIPATES WITH (CHECK ALL THAT APPLY): <input type="checkbox"/> VOUCHERS <input type="checkbox"/> SPECIAL NUTRITION <input type="checkbox"/> RSPMI <input type="checkbox"/> DDTCS <input type="checkbox"/> CHMS <input type="checkbox"/> 21CCLC <input type="checkbox"/> S21C	

CURRENT ENROLLMENT # OF CLASSROOMS & TEACHERS:

(List each classroom separately)

Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____
Room Age: _____	# Children: _____	# Teachers/Caregivers: _____

Total # of Rooms: _____

AUTHORIZATION

On behalf of the licensed school-age facility, I hereby voluntarily apply for participation and certification with Better Beginnings, Arkansas' Quality Rating Improvement System.

I hereby understand and agree to the following:

- That the facility (physical space, records, etc.) must be accessible for on-site visits with or without notice.
- To provide all documentation necessary for certification.
- My facility's licensing history and status with other DHS programs will be subject to review.
- That the Division of Child Care and Early Childhood Education may access TAPP Registry records for compliance.
- That an Application Checklist (Better Beginnings Form B) for the appropriate facility type must accompany this form.
- That the Annual Staff Record (Better Beginnings Form C) and all related documentation must accompany this form. I agree to provide an updated Staff Record (Better Beginnings Form C) and all related documentation to the Division of Child Care and Early Childhood Education annually.
- All information contained in this application and in accompanying documents is true and correct to the best of my knowledge.

Administrator Signature

Date

OFFICIAL USE ONLY:

LICENSING COMPLIANCE VIEWED:

DATE KEYED:



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BETTER BEGINNINGS APPLICATION CHECKLIST SCHOOL-AGE

Mark each requirement in the box "YES" or "NO" according to whether or not the requirement has already been met. Mark "YES" only if you have written documentation. For items which require an assessment score, a mark of "YES" means the facility has reviewed the tool and believes the necessary score is possible upon assessment.

A "YES" mark for each requirement under a level will allow the facility to be considered for that level; the highest level with all "YES" responses will be considered first. A mark of "NO" in any column may indicate the facility is not yet ready to meet all requirements of that level and the facility may request technical assistance or refer to the Better Beginnings Toolkit.

Level 1		YES	NO
1.A.1	Administrator attends "PAS Basics" training.		
1.B.1	Administrator and teaching staff are members of the TAPP Registry and/or ADE Registry.		
1.B.2	Administrator meets requirements for TAPP Foundation 3 or higher, including 21 clock hours of training in program planning/management and/or leadership.		
1.B.3	All staff meet requirements for TAPP Foundation 1 or higher.		
1.B.4	Administrator completes an ERS or YPQA Training.		
1.B.5	Administrator completes training on developmentally appropriate physical activities for children/youth.		
1.C.1	A developmentally appropriate daily program schedule is posted in each classroom/program area.		
1.C.2	Staff develop and implement written daily plans for each group.		
1.D.1	Facility completes a self-evaluation using an applicable approved environment rating tool (SACERS or YPQA).		
1.E.1	Facility documents distribution of ARKids First information to families of uninsured children/youth.		
1.E.2	Facility shares with families information on child/youth development and on children's/youth health.		
1.E.3	Any medical and educational care plans involving a child/youth are written and on file, and implementation is documented.		

Level 2		YES	NO
2.A.1	A program review is completed by a certified PAS assessor.		
2.A.2	Administrator completes Strengthening Families Webinar.		
2.B.1	Administrator and teaching staff maintain membership in the TAPP Registry and/or ADE Registry.		
2.B.2	Administrator meets requirements for TAPP Intermediate 1 or higher, including 30 clock hours of training in program planning/management and/or leadership.		
2.B.3	All staff meet requirements for TAPP Foundation 1 or higher and at least 50% of teaching staff meet requirements for TAPP Foundation 2 or higher.		
2.B.4	All administrators and teaching staff participate annually in 20 clock hours of approved professional development; for administrators, at least 3 clock hours must be in program planning/management and/or leadership.		
2.B.5	At least 50% of teaching staff complete "Developmental Assets Basics" training.		

2.B.6	All administrative staff and 50% of teaching staff complete an ERS or YPQA training.		
2.B.7	Administrator and kitchen manager (if applicable) participate annually in at least 2 clock hours of training on nutrition for children/youth.		
2.C.1	All classrooms/program spaces have a minimum of two (2) clearly defined interest centers if not utilizing single-use spaces.		
2.C.2	Written daily plans for each group include the Developmental Assets concepts.		
2.C.3	Staff plan and implement daily developmentally appropriate physical activities for all children/youth.		
2.D.1	Facility scores an average of 3.00 or higher on the SACERS or scores 3.00 or higher on the YPQA/YPQA for each classroom/program space reviewed. School Age assessment tool choice: <input type="checkbox"/> SACERS <input type="checkbox"/> YPQA <input type="checkbox"/> YYPQA		
2.E.1	Facility shares with families information regarding medical homes for children/youth.		
2.E.1	Facility shares with families information regarding child/youth development.		

Level 3		YES	NO
3.A.1	Facility scores an average of 4.00 or higher on PAS items 1-21 (items 5 and 6 scored, but not included in average; items 10 and 11 not scored).		
3.A.2	Administrator completes Strengthening Families online self-assessment for 3 or more Strategies.		
3.A.3	Facility develops a Strengthening Families action plan and implements at least 1 action step.		
3.B.1	Administrator meets requirements for TAPP Intermediate 1 or higher, including 45 clock hours of training in program planning/management and/or leadership.		
3.B.2	All staff meet requirements for TAPP Foundation 1 or higher and at least 50% of teaching staff meet requirements for TAPP Foundation 3 or higher.		
3.B.3	All administrators and teaching staff participate annually in 25 clock hours of approved professional development; for administrators, at least 4 clock hours must be in program planning/management and/or leadership.		
3.C.1	All classrooms/program spaces have a minimum of three (3) clearly defined interest centers if not utilizing single-use spaces.		
3.C.2	Staff maintain a portfolio for each child/youth.		
3.C.3	Facility develops a current written curriculum plan and daily plans that include links to ADE K-12 frameworks.		
3.D.1	Facility scores an average of 4.00 or higher on the SACERS or scores 3.75 or higher on the YPQA/YPQA for each classroom/program space reviewed. School Age assessment tool choice: <input type="checkbox"/> SACERS <input type="checkbox"/> YPQA <input type="checkbox"/> YYPQA		
3.E.1	Facility shares with families information on nutrition and physical activity for children/youth.		

Comments: _____



BETTER BEGINNINGS ANNUAL STAFF RECORD

The Annual Staff Record form C must be submitted as part of the Better Beginnings application and again at 12 and 24 months after certification or renewal to remain in compliance with certification requirements. Complete the form as follows; attach additional copies as necessary.

Initial Application:

- Include all current employees, their TAPP or ADE Registry numbers and date of hire. NOTE: Some support staff may not be subject to professional development requirements, regardless, please list all employees in the appropriate area.
- Mark "F" for full-time (35 hours per week or more) or "P" for part-time (20-34 hours per week). For seasonal staff or staff regularly scheduled for fewer than 20 hours per week, mark an "X" in that column.
- For each employee, indicate whether the position held is teaching staff (regularly assigned to work with children/students in program activities), administrative staff (director, manager, office administrative personnel, supervisor, coordinator; kitchen manager is listed in this area) or support staff (e.g.: all other facility employees).
- For each employee specify the level of TAPP for which the employee meets the requirements.

Foundation 1: F1	Foundation 2: F2	Foundation 3: F3
Intermediate 1: Int. 1	Intermediate 2: Int. 2	Intermediate 3: Int. 3
Advanced 1: Adv. 1	Advanced 2: Adv 2	
- For each employee place a checkmark (✓) for each training listed which the person has completed and record total number of approved professional development training hours for the past calendar year; be sure at least 12 months of time is recorded.
- Retain copies of the Staff Record form for continued yearly use.
- Attach documentation for training not yet recorded in TAPP; attach ADE transcripts.

Annual Report: (12 months after certification and 24 months after certification)

- Use copies of the form last submitted.
- Mark a single line through persons listed who are no longer employed.
- If an employee has changed levels (support, teaching, administrative) highlight their name and re-record on a new line in the current level.
- Add new employees to the list; use additional copies of the form as necessary.
- Update each employee's training record to reflect current status.

BETTER BEGINNINGS ANNUAL STAFF RECORD

TEACHING STAFF RETENTION:

Calculate the annual turnover of teaching staff at your facility as follows:

Divide the number of teaching staff who left in the past 12 months by the total number of teaching staff positions available.

$$\frac{\text{Total staff that left}}{\text{Total positions available}} = \text{Subtotal}$$

Multiply the subtotal from above by 100. This gives you your percentage of turnover for the past year.

$$\frac{\text{Subtotal}}{\text{Subtotal}} \times 100 = \text{Turnover}$$

Complete the following table, inserting current data at application and at 12 and 24 months:

	Initial Application	12 Months	24 months
Annual Turnover			

Administrator Signature Year 1

Date

Administrator Signature Year 2

Date

Administrator Signature Year 3

Date



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BETTER BEGINNINGS FACILITY SELF-EVALUATION

Facility Name: _____

Facility Number: _____

Identify the assessment tool(s) used for the facility.

Select all that apply:

ITERS

ECERS

FCCERS

SACERS

YPQA

YYPQA

Identify the self-assessment method being submitted

Copy of score sheet from assessment materials with each subscale marked

Subscale self-evaluation from Better Beginnings Tool Kit

An external assessor has conducted a review(s) or Technical Assistance visit using a rating scale on the following date(s) (copies not required):

Other type of self-evaluation or checklist, not listed above (must include some subscale items and not only an overall score estimation) please specify:

Be sure that EACH document set is labeled with your facility name and facility number.

Administrator Signature

Date



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BETTER BEGINNINGS ARKIDS FIRST, CHILD HEALTH AND CHILD DEVELOPMENT

Facility Name: _____

Facility Number: _____

Attach the written policy or procedure describing the method(s) your facility uses to distribute ARKids First information to families. Include a sample of the method (e.g.: page from a handbook, copy of newsletter etc.). List examples of information on child development and child health that you have shared with families in the past 12 months. Indicate the way(s) in which it was shared with families.

Description of information	Date	Bulletin Board	Handout	Newsletter	Handbook	Other (specify)

Administrator Signature

Date



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BETTER BEGINNINGS MEDICAL & EDUCATIONAL CARE PLANS

Facility Name: _____

Facility Number: _____

Attach the written policy or procedure describing the method(s) your facility uses for obtaining and implementing children's medical and educational plans.

Administrator Signature

Date