



## BETTER BEGINNINGS APPLICATION

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FACILITY INFORMATION		
FACILITY TYPE: <input type="checkbox"/> CENTER <input type="checkbox"/> LICENSED HOME <input type="checkbox"/> REGISTERED HOME		
<input type="checkbox"/> NEW APPLICANT <input type="checkbox"/> CERTIFIED-REQUESTING NEW LEVEL <input type="checkbox"/> CERTIFIED- CHANGE IN LOCATION / OWNER (Circle one)		
<input type="checkbox"/> 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: <input type="checkbox"/> OPEN YEAR ROUND <input type="checkbox"/> OPEN PART YEAR: FROM _____ TO: _____		
FACILITY IS OPEN: <input type="checkbox"/> 20 HOURS OR FEWER PER WEEK <input type="checkbox"/> 40 HOURS OR FEWER PER WEEK <input type="checkbox"/> 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.)	
FACILITY DEMOGRAPHICS		
LICENSED CAPACITY: INFANT/TODDLER: _____ PRESCHOOL: _____ SCHOOL AGE: _____ LICENSED HOME: _____ REGISTERED HOME: _____	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"/> ABC <input type="checkbox"/> HEAD START <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: \_\_\_\_\_ Infant \_\_\_\_\_ Toddler \_\_\_\_\_ Preschool \_\_\_\_\_ School-Age

**AUTHORIZATION**

On behalf of the licensed or registered child care 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/registration history will be subject to review.
- That an Application Checklist (Better Beginnings Form B) for the appropriate facility type must accompany this form.
- That the Division of Child Care and Early Childhood Education may access TAPP Registry records for compliance.
- That an Annual Staff Record (Better Beginnings Form C) and all related documentation must accompany this form. I agree to provide an Annual 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:



## BETTER BEGINNINGS APPLICATION CHECKLIST FAMILY CHILD CARE HOME

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.

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Level 1		YES	NO
1.A.1	Primary caregiver attends "BAS Basics" training.		
1.B.1	Primary and secondary caregivers are members of the TAPP Registry and/or ADE Registry.		
1.B.2	Primary caregiver meets requirements for TAPP Foundation 2 or higher.		
1.B.3	Primary caregiver completes an ERS training.		
1.B.4	Primary caregiver completes training on developmentally appropriate physical activities for children.		
1.C.1	A developmentally appropriate daily program schedule is posted in each program area.		
1.C.2	Caregivers develop and implement written daily plans for each group.		
1.D.1	Facility completes a self-evaluation using the FCCERS.		
1.E.1	Facility documents distribution of ARKids First information to families of uninsured children.		
1.E.2	Facility shares with families information on child development and on children's health.		
1.E.3	Any medical and educational care plans involving a child are written and on file, and implementation is documented.		

Level 2		YES	NO
<i>Registered facilities meet licensing ratios</i>			
2.A.1	A program review is completed by a certified BAS assessor.		
2.A.2	Primary caregiver views Strengthening Families Webinar.		
2.B.1	All caregivers maintain membership in the TAPP Registry and/or ADE Registry.		
2.B.2	Primary caregiver meets requirements for TAPP Foundation 3 or higher.		
2.B.3	At least 50% of secondary caregivers meet requirements for TAPP Foundation 1 or higher.		
2.B.4	Primary caregiver participates annually in 20 clock hours of approved professional development.		
2.B.5	Primary caregiver completes "Framework Basics" training.		

2.B.6	Primary caregiver participates annually in at least 2 clock hours of training on nutrition for children.		
2.C.1	Program spaces have a minimum of two (2) clearly defined interest centers.		
2.C.2	Written daily plans for each group include all areas of development.		
2.C.3	Caregivers plan and implement daily developmentally appropriate physical activities for all children.		
2.D.1	Facility scores an average of 3.00 or higher on the FCCERS.		
2.E.1	Facility shares with families information regarding medical homes for children.		
2.E.2	Facility shares with families information regarding stages of development for children.		

Level 3		YES	NO
<i>Facility is a licensed Family Child Care Home</i>			
3.A.1	Facility scores an average of 4.00 or higher on BAS items 2-10 (item 2 is scored, but not included in average).		
3.A.2	Primary caregiver completes Strengthening Families online self-assessment for 3 or more strategies.		
3.A.3	Primary caregiver develops a Strengthening Families action plan and implements at least 1 action step.		
3.B.1	Primary caregiver meets requirements for TAPP Foundation 3 or higher and has an additional 15 clock hours.		
3.B.2	All secondary caregivers meet requirements for TAPP Foundation 1 or higher and at least 50% of secondary caregivers are at TAPP Foundation 2 or higher.		
3.B.3	Primary caregiver participates annually in 25 clock hours of approved professional development.		
3.C.1	Program spaces have a minimum of three (3) clearly defined interest centers.		
3.C.2	Caregivers maintain a portfolio for each child.		
3.C.3	Facility develops a current written curriculum plan and daily plans that include learning goals for children.		
3.D.1	Facility scores an average of 4.00 or higher on the FCCERS.		
3.E.1	Facility shares with families information on nutrition and physical activity for children.		

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



## 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