



ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Child Care and Early Childhood Education
Child Care Arrangement Verification

This is NOT an approval for services.

Name of Casehead/Applicant _____

The information below must be completed by the CHILD CARE PROVIDER where children are either currently attending or will be attending.

CHILD CARE PROVIDER: List children of casehead who are enrolled and complete all applicable information for each child. Return form to casehead upon completion.

Child's Name	Age	Start Date	Head Start/ABC	Type of Service Requested	Time of Service Requested	Cost Per Day
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$

***Types of Service:**

- Full Day: More than 5 hours per day and up to 10 hours
- Half-Time: 3-5 hours per day, inclusively (Hours do not have to be consecutive.)
- Part-Time: Less than 3 hours per day
- Night: Weekday when more than 1/2 of total care is after 6:00 p.m.
- Weekend: Care on Saturday and/or Sunday

Signature of Facility Director of Designee		Print Name	
Name of Child Care Facility		Telephone Number	
Mailing Address	City	Zip Code	County
License No.	<input type="checkbox"/> YES <input type="checkbox"/> NO Quality Approved?		

Check type of facility: Child Care Center Licensed Child Care Family Home Registered Child Care Family Home
 Voluntary Registered Home Other: _____

Casehead: Complete and return this form to your Child Care Eligibility Specialist. If you have any questions, please contact your specialist or the Family Support Unit at 1-800-322-8176 or 501-682-8947.