



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 # (Optional) 448-98-0941	First Name MI Last Name (applicant) Jenna E. Clark			Date of Birth 3-18-84	Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Race (see codes): W	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino	Primary Language: English	# of Parents in home: 2	Household Size: 4	Highest Level of Education or Training Completed: Bachelor's degree				
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 2633 N. Indian Oaks		City/State Fayetteville, AR		Zip 72704	County Washington	Home Phone/Cell: 479-422-2290			
Street Address (if not the same)		City/State		Zip	County	Message Phone:			
Current/Valid Email Address (required) Clark.jennae@gmail.com			Do you have assets in excess of \$1,000,000? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		School District (No abbreviations): Springdale School District				
HOUSEHOLD INFORMATION: * A family's eligibility group is made up of one (1) or more adults who are working and child(ren) related by blood or law residing in the same house when at least one of the adults has physical custody of the child(ren) for whom application is made.									
Social Security #	First Name	MI	Last Name	Date of Birth:	Gender	Citizen/ Legal Resident	Relationship to Parent/ Guardian	Child Care Needed	Race (see codes)
373-43-252	London	E	Clark	1-13-13	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	daughter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	W
069-43-0151	Sydney	R	Clark	3-1-16	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	daughter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	W
					<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
If Yes, check the areas that apply to you below:									
<input type="checkbox"/> Emergency Responders					<input checked="" type="checkbox"/> Public Health personnel (water & wastewater)				
<input checked="" type="checkbox"/> Health Care Providers					<input type="checkbox"/> Child Care personnel				
<input type="checkbox"/> Manufacturing Workers					<input type="checkbox"/> Food Supply Chain personnel				
<input type="checkbox"/> Sanitation Workers									
Name of Employer:		MANA Medical Assoc.			Supervisor or Human Resources Contact: Dawn Hellard				
Phone Number:		479-582-7302			Email Address: dawn.hellard@mana.md				
Spouse Information (if applicable):									
Name of Employer:		Springdale Water Utilities			Supervisor or Human Resources Contact: Kim Patulak (HR)				
Phone Number:		479-751-5751			Email Address: kpatulak@springdalewater.com				
CERTIFICATION: 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 <i>Jenna Clark</i>					Applicant Signature Date 8/8/20				
Child Care Provider Information:									
Child Care Provider Signature <i>Jandy Hanson</i>					Child Care Provider Signature Date 8/12/2020				
Child Care Provider License No. 28546					Quality Approved? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Better Beginnings Level <input checked="" type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3		

Start Date: 8/24/2020





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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 eligible families in the state of Arkansas.

IN ORDER TO PROCESS YOUR ESSENTIAL SERVICE 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/Proof of Citizenship 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.  
☒ **Valid email address**  
☒ **Copy of a Social Security Card for each child needing assistance**

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

Child Care personnel  
Public Health personnel  
Food Supply Chain personnel

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

Family Size	Income Eligible	Over Income
2-Person Families	\$2,954.97	\$2,954.98
3-Person Families	\$3,650.76	\$3,650.77
4-Person Families	\$4,345.54	\$4,345.55
5-Person Families	\$5,040.83	\$5,040.84
6-Person Families	\$5,736.12	\$5,736.13
7-Person Families	\$5,866.49	\$5,866.50
8-Person Families	\$5,996.85	\$5,996.86
9-Person Families	\$6,127.22	\$6,127.23
10-Person Families	\$6,257.59	\$6,257.60
11-Person Families	\$6,387.95	\$6,387.96