



ARCHS' EARLY AND RE-ACCREDITATION APPLICATION

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|--|---|-------------------|--|-----------|--|
| APPLICATION DATE: | | NAME OF CENTER: | | | |
| STREET ADDRESS: | | | | | |
| CITY: | | STATE: | | ZIP CODE: | |
| PHONE NUMBER: | | | FAX NUMBER: | | |
| E-MAIL: | | | | | |
| DIRECTOR: | | | OWNER: | | |
| LICENSE NUMBER: | | | LICENSE EXPIRATION DATE: | | |
| LICENSE CAPACITY: | # DSS SUBSIDIZED ENROLLED: | TOTAL # ENROLLED: | DO YOU SERVE CHILDREN WITH IDENTIFIED SPECIAL NEEDS? | | |
| WHAT IS THE SQUARE FOOTAGE OF SPACE USED FOR CHILDREN? | HOW LONG HAS YOUR FACILITY BEEN IN OPERATION? | | WHAT ARE YOUR PROGRAM'S HOURS OF OPERATION? | | |
| ACCREDITATION STATUS- Please type an 'x' in the relevant box. | | | | | |
| <input type="checkbox"/> NOT YET ACCREDITED; HAVE NEVER APPLIED FOR ACCREDITATION <input type="checkbox"/> NOT YET ACCREDITED; APPLIED FOR ACCREDITATION BUT WAS NOT AWARDED <input type="checkbox"/> CURRENTLY ACCREDITED; SEEKING RE-ACCREDITATION ON _____(date) | | | | | |
| ACCREDITATION PROGRAM | | | | | |
| <input type="checkbox"/> NAEYC <input type="checkbox"/> MOA <input type="checkbox"/> NAFCC *if NAFCC, do you have the capacity to care for at least one unrelated child? ____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNDECIDED <i>*It is not necessary to choose an accrediting body at this point if you have not yet been accredited*</i> | | | | | |
| TYPE OF FACILITY | | | | | |
| <input type="checkbox"/> ½ DAY PRESCHOOL <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> GROUP HOME <input type="checkbox"/> FAMILY DAY CARE | | | | | |



| NUMBER OF CLASSROOMS <i>*for reporting purposes, toddler classes are for children 30 months and under, classes with children over the age of 30 months are considered preschool*</i> | | | | |
|---|--------------------|----------|----------------------|-----------------------|
| INFANT CLASS(ES): | TODDLER CLASS(ES): | | PRESCHOOL CLASS(ES): | SCHOOL-AGE CLASS(ES): |
| AGE OF CHILDREN | ENROLLED | CAPACITY | ADULT/CHILD RATIO | DAILY RATE |
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| STAFF EDUCATIONAL LEVELS- How many staff members, including yourself, are educated at the levels listed below: | | | | |
| GED | | | AA Degree | |
| High School Diploma | | | BA or higher | |
| CDA | | | | |
| NUMBER OF STAFF MEMBERS | | | | |
| TEACHING STAFF: | | | NON-TEACHING STAFF: | |
| PLEASE LIST ALL NON-TEACHING STAFF, OUTSIDE CONSULTANTS, ETC. BY SPECIFIC DUTY: | | | | |
| | | | | |
| WHAT CURRICULUM ARE YOU CURRENTLY USING? | | | | |
| <input type="checkbox"/> NONE-WE ARE STILL SEARCHING FOR A CURRICULUM THAT IS RIGHT FOR OUR PROGRAM <input type="checkbox"/> CREATIVE CURRICULUM <input type="checkbox"/> WEST ED (PITC) <input type="checkbox"/> MONTESSORI <input type="checkbox"/> EMOTIONAL BEGINNINGS <input type="checkbox"/> HIGH SCOPE <input type="checkbox"/> REGGIO EMILIA <input type="checkbox"/> OTHER _____ (IS ABOVE LISTED "OTHER" CURRICULUM APPROVED BY THE STATE OF MISSOURI?) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| NARRATIVE- Your answers to the following questions will be scored. Please include enough detail to answer each question thoroughly. Please respond only to the question being asked. The purpose of this section is to determine your program's readiness to begin the process of quality improvement and accreditation self-study. | | | | |
| Tell about your program's mission and how it fits in the community. | | | | |
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| How familiar are you with the accreditation process? |
| How will obtaining accreditation help you to improve the quality of program you are currently offering? |
| How have you prepared your teachers for the process of accreditation? |
| What is your annual percentage of staff turnover? <input type="checkbox"/> high (75-100%) <input type="checkbox"/> moderate (25-75%) <input type="checkbox"/> low (0-25%) What are the possible reasons for staff turnover, and what measures to you take in regards to staff turnover? |
| What are three strengths of your current program? |
| What are three weaknesses of your current program? |



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| <p>What kind of support system do you have to help you as you work through this process?(other partnerships, grants, memberships, resources, relationships, etc. Ex: Involvement with the CDCA's Social Emotional program)</p> | |
| <p>Explain your commitment to this partnership, including your availability to attend monthly meetings and complete all ARCHS reports.</p> | |
| <p>DATE OF ARCHS REVIEW:</p> | <p>REVIEWER SIGNATURE:</p> |