



BEST IN CLASS CONTINUATION INTEREST APPLICATION 2025-2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES

EARLY CHILDHOOD

SFN 582 (1-2025)

PROGRAM INFORMATION

Program Name		Program Telephone Number	
Program Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
Applicant Name	Title		
Email Address	County		
Point of Contact for the Best in Class Program (if not applicant)	Point of Contact Title	Point of Contact Email Address	
Business Manager Name	Business Manager Email Address		

Site Classification (check all that apply)

☐ Public School/Non-Public

☐ Current Four-Year Old Program Approval (renewal is every two years) - State School Site ID Number: _____

☐ Licensed Child Care

Bright and Early of ND Quality Rating Step	Bright and Early Expiration Date
NAEYC Accreditation Expiration Date	License Number

☐ Head Start - Head Start State ID Number: _____

Are you interested in participating in Best in Class in 2025-2026?

☐ No - complete program information only (above) and submit to dhsec@nd.gov

☐ Yes - all sections of the application must be completed.

BEST IN CLASS GRANT ASSURANCES & REQUIREMENTS

- ☐ I acknowledge all of the staff and stakeholders impacted by this award have read through the Best in Class Program description and standards.
- ☐ I acknowledge my Best in Class program is to operate for at least 400 hours over a period of at least 32 consecutive weeks. I am committed to offering the number of hours and number of weeks that are stated in my Interest Application for the period of the award.
- ☐ I acknowledge all children enrolled must be four years old before August 1, 2025.
- ☐ I acknowledge family participation is a requirement of Best in Class. Our program will commit to incorporating at least 10 hours of researched-based family engagement.
- ☐ I acknowledge the lead teaching staff will meet Best in Class teacher qualifications.
- ☐ I acknowledge each of my Best in Class section(s) is required to establish a 50% set-aside to enroll children whose family's income meet 60% of the state median income or less, or children with identified disabilities or development delays.
- ☐ I acknowledge my Best in Class program will implement randomized selection of children.
- ☐ I acknowledge lead teachers will complete a minimum of 15 hours of early childhood specific professional development.
- ☐ I acknowledge Best in Class requires all lead teachers to successfully complete Interrater Reliability certification (IRR) every three years. Teaching staff will need additional work time to complete IRR.
- ☐ I acknowledge my Best in Class program is required to use Teaching Strategies GOLD for observations and assessment under the state's contract and cannot use a private license while participating in Best in Class. An IRR certified teacher will be required to assess children for three GOLD checkpoints throughout the school year (Fall 9/1-11/30, Winter 12/1-2/28, Spring 3/1-5/31)

- ☐ I acknowledge my program staff will participate fully in the relationship-based coaching, training and support efforts provided by the state.
- ☐ I acknowledge my Best in Class program will implement a research-based curriculum. Creative Curriculum is offered to program participants at no cost.
- ☐ I acknowledge providing health screenings (dental, vision, hearing, physical & developmental) is a requirement for my Best in Class program to be completed no sooner than six months prior to the first day of attendance and no later than the last business day of November.
- ☐ I acknowledge my Best in Class program will participate fully in the research and evaluation efforts that are part of the program.
- ☐ I acknowledge my Best in Class program will communicate program expectations and collect data consent forms from families.
- ☐ I acknowledge my program will use the awarded dollars for eligible expenses and will prioritize the learning environment, screenings and helping families attend referral appointments.
- ☐ I acknowledge if my Best in Class program charges tuition it will be based on the Best in Class program Sliding Fee Scale or less.
- ☐ I acknowledge my program is required to provide an in-kind match equal to 15% of my total award. My program will submit deliverables at each of the scheduled milestones, along with a completed SFN1763 Request for Reimbursement-Direct Service.
- ☐ I acknowledge the award may be recaptured if the program is found to be out of compliance.

This signature certifies that the applicant has read the assurances and requirements and agrees to follow the requirements should this application be approved and funded.

Signature	Date
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PROGRAM STANDARDS

Number of returning Four-Year Old sections requesting Best in Class funding in 2025-2026

- ☐ Small Group (8-10 children; 1 staff) - Number of Section(s): _____
- ☐ Large Group (11-20 children; 2 staff) - Number of Section(s): _____

Are you seeking Best in Class funding for additional Four-Year-old section(s)? ☐ No ☐ Yes - Answer below:

- ☐ Small Group (8-10 children; 1 staff) - Number of Section(s): _____
- ☐ Large Group (11-20 children; 2 staff) - Number of Section(s): _____

Specify how many hours you will operate each section of Best in Class:

Number of Hours per Day/Single Section	×	Number of Operating Days per Year	=	Total Hours
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Four-Year Old Schedule of Operation (i.e. M-F 8:30-3:00)	Start Dates	End Dates
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Attach your anticipated daily four-year old program schedule (including start and end times).

PROFESSIONAL QUALIFICATIONS

Best in Class requires one staff to every ten children. (Ex. 11 children requires 1 teacher and 1 auxiliary teacher.)

2025-2026 Lead Teacher(s)

First, Last and Maiden Name	Email Address	Child Development Associate (CDA) (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Teaching License (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No
First, Last and Maiden Name	Email Address	Child Development Associate (CDA) (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Teaching License (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No
First, Last and Maiden Name	Email Address	Child Development Associate (CDA) (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Teaching License (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No
First, Last and Maiden Name	Email Address	Child Development Associate (CDA) (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Teaching License (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No

☐ Best in Class teacher has not been identified.

2025-2026 Auxiliary Teacher(s)

First and Last Name	Email Address
First and Last Name	Email Address
First and Last Name	Email Address
First and Last Name	Email Address

☐ Best in Class para/assistant has not been identified.

ACCESSIBILITY AND AFFORDABILITY

Enrollment

How will you ensure children enrolling into the Best in Class program are four years old before August 1st, 2025?

What is your marketing and recruitment plan to enroll children whose family's income meet the 60% state median income or less, or who have an identified delay or disability?

When will you hold your randomized selection enrollment process? (Refer to Program Description for explanation of process)

Tuition

Without the Best in Class Award would you rely on the revenue of the fees from the families enrolled to operate your four-year old program?

☐ No ☐ Yes - At what level? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

BIC programs that charge tuition must use the approved sliding fee scale or charge less.

Will you charge tuition for participants in Best in Class?

☐ No ☐ Yes

Describe other funds used to cover operating cost

Screenings

Best in Class requires all participating children to be provided health screenings (dental, vision, hearing, physical & developmental) to be completed no sooner than six months prior to the first day of attendance and no later than the last business day of November.

Which developmental screening tools(s) will be used (must include all domains)?

- ☐ Ages & Stages Questionnaire Third Edition (ASQ-3)
☐ Brigance Early Childhood Screen II or III
☐ Developmental Indicators for the Assessment of Learning, Third or Fourth Edition (DIAL-3 or 4)
☐ Other (specify name): _____

Name of Person to Coordinate Scheduling the Screenings

Email Address

Transportation

Do you offer transportation for children attending the Four-Year Old program?

- ☐ Currently Offer ☐ Do Not Offer ☐ Plan to Offer ☐ N/A - Child Care or all day Head Start

Additional Care

Do you provide care before and after your Best in Class section(s)?

- ☐ Before ☐ After ☐ Both Before/After
☐ No - How do you support working families needing child care? (Explain below):

CLASSROOM AND SUPPORT

Family Engagement

Ten hours of family engagement is a requirement of Best in Class. What family engagement opportunities are you offering?

- ☐ Ready Rosie ☐ Other - specify:

Curriculum

What Curriculum(s) are you currently using to support all areas of development? If not using Teaching Strategies- Creative Curriculum, have you aligned the curriculum with ND Early Learning Standards (Refer to Program Description)? If yes, please attach.

This application is complete and all information is accurate to the best of my knowledge.

Signature

Date

Submit completed application to: dhsec@nd.gov