

# Gateways to Opportunity® Credentials

## Supplement Application

### Family Specialist Credential

For questions and additional information about the Gateways Credential Program please call 866.697.8278 or visit us at [www.ilgateways.com](http://www.ilgateways.com). **Please read through the Frequently Asked Questions before completing this application.** Please complete in blue or black ink.

#### Family Specialist Credential

Level 2–5 (\$65 application fee required)

☐ New    ☐ Renewal    ☐ Level Advancement

**Do you have a Bachelors or Graduate degree in Social Work?**

☐ Yes    ☐ No

If yes, please list graduating institution: \_\_\_\_\_

**How did you first learn about Gateways to Opportunity Credentials?** *(check only one)*

☐ Center Director    ☐ Local Child Care Resource & Referral    ☐ Conference/Presentation  
☐ Mailing    ☐ Co-Worker    ☐ Provider Association  
☐ Website/Social Networking    ☐ Professional Development Advisor (PDA)    ☐ Other \_\_\_\_\_

#### APPLICANT SIGNATURE

I verify that I have read this paragraph and that all information provided is true and accurate. By signing below I understand that INCCRRA will use my signature as authorization to verify any information and documents I have submitted. I understand that the Illinois Department of Human Services may use my name and application information for research/evaluation purposes. I understand that any false or misleading statements or subsequent documentation may constitute grounds for denial or subsequent withdrawal of any Gateways to Opportunity Credential. *Additional information may be required.*

**Print Name:** \_\_\_\_\_

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mail completed application to: INCCRRA/Applications • 1226 Towanda Plaza • Bloomington, IL 61701**

# Gateways Family Specialist Credential

## Work & Practical Experience—Verification Form

Please complete this form to validate your work experience providing direct service to families.

**Use a separate form for each position.** Attach a job description from your employer and write 3 or 4 sentences that describes your **daily direct contact with families** that promote optimal child and family outcomes.

If you have a Bachelors or Graduate degree in Social Work with an internship of 200 hours or more, please complete **Step 1, sign** and **return**.

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### Step 1: Personal Information

Name: \_\_\_\_\_ Registry Member ID: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Step 2: Work Experience:

Position: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Total hours worked providing direct services to families: \_\_\_\_\_  
(Hours Per Week x By Weeks Per Year x By Number Of Years)

### Step 3: Family Specialist Experience Verification

Please provide the name and contact information for someone that could verify your experience providing direct services to families that promote optimal child and family outcomes. (Examples include: director, professional colleagues or previous employers.) Please note: we may contact to verify.

Contact Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Affiliation to applicant (*How is this contact knowledgeable about your experience providing direct services to families?*):

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**Participant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

By signing the above, I verify that the information provided herein is accurate and correct to the best of my knowledge. I understand false or misleading statements or subsequent documentation may constitute grounds for denial of a Gateways to Opportunity Credential.



# Information Update Form

## SECTION 1 - CONTACT / PERSONAL INFORMATION

The Information Update form is used to update your information. Please fill out the Information Update Form and the corresponding program supplement to participate in a Gateways program. For questions and additional information please call (866) 697-8278 or visit us at [www.ilgateways.com](http://www.ilgateways.com).

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Has your name changed in the last 12 months? ☐ Yes ☐ No If yes, list previous name: \_\_\_\_\_

Person ID/Registry Member ID: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Please contact me at my: ☐ Home Address/Phone ☐ Work Address/Phone (if completing section 2)

## SECTION 2 – CURRENT EMPLOYMENT

Please complete this section only if you are currently in part-time or full-time paid employment in the fields of Early Care and Education, School-Age, Youth Development, or Early Childhood Family Support. **If this does not apply to you, please skip this section.**

Employer Business Name: \_\_\_\_\_

Work Site Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_

**Type of Program:** (check only one)

- |  |   |
|--|---|
| <input type="radio"/> Child Care Center            | <input type="radio"/> School-Age/Youth Development Program Only |
| <input type="radio"/> Family Child Care Home       | <input type="radio"/> Public or Private School                  |
| <input type="radio"/> Group Family Child Care Home | <input type="radio"/> Child Care Resource & Referral (CCR&R)    |
| <input type="radio"/> Head Start                   | <input type="radio"/> Other _____                               |

**This program is:** ☐ Licensed by Illinois Department of Children and Family Services\* ☐ License-Exempt ☐ N/A

\*If Licensed, License ID number: \_\_\_\_\_ Licensed Capacity: \_\_\_\_\_

Date Employment Began: *(with this employer)* \_\_\_\_\_

Current Position Title: \_\_\_\_\_ Position Code: \_\_\_\_\_

Current Position Start Date: \_\_\_\_\_ *(refer to below)*

Hours worked per week: \_\_\_\_\_ Weeks worked per year: \_\_\_\_\_

#### Position Codes *(to be used above)*

##### Direct Services to Children

- |   |   |
|---|---|
| 1. Director and/or Administrator (one-site) | 10. Group Family Child Care Provider      |
| 2. Assistant Director                       | 11. Group Family Child Care Assistant     |
| 3. Director/Teacher                         | 12. School-Age Child Care Teacher         |
| 4. Teacher                                  | 13. School-Age Child Care Assistant       |
| 5. Assistant Teacher                        | 14. Youth Development Practitioner        |
| 6. Teacher Aide (Preschool for All)         | 15. Other Direct Service                  |
| 7. Substitute/Floater                       | 23. Home Visitors                         |
| 8. Family Child Care Provider               | 24. Home Visitor Supervisor               |
| 9. Family Child Care Assistant              | 25. Family, Friend, or Neighbor Caregiver |

##### Indirect Services

- |   |                                      |
|---|--------------------------------------|
| 16. Director/Administrator (multi-site) | 20. Education/Curriculum Coordinator |
| 17. CCR&R Staff                         | 21. Consultant                       |
| 18. Higher Education Faculty/Staff      | 22. Other Indirect Services          |
| 19. Trainer                             |                                      |

#### Ages of Children You Currently Work With *(Family Child Care check all that apply, others check only one.)*

- |   |  |
|---|--|
| <input type="radio"/> Infant <i>(6 wks-14 months)</i> | <input type="radio"/> School-Age <i>(K-12 years)</i> |
| <input type="radio"/> Toddler <i>(15-23 months)</i>   | <input type="radio"/> Youth <i>(13-21 years)</i>     |
| <input type="radio"/> Twos <i>(24-35 months)</i>      | <input type="radio"/> Not Applicable <i>(N/A)</i>    |
| <input type="radio"/> Preschool <i>(3-5 years)</i>    |  |

### SECTION 3 – APPLICANT SIGNATURE

I verify that all information provided is true and accurate. I understand that INCCRRA or the Illinois Department of Human Services may use my information for research/evaluation purposes. For more information, please view the Privacy Policy at: [www.ilgateways.com](http://www.ilgateways.com). I also understand that I will become a member of the Gateways to Opportunity Registry. I understand that periodically a **limited** amount of my Registry record information may be released to IDCFS, IDHS, OECD and/or my program administrator in order to verify compliance with State requirements and/or ExceleRate Illinois standards. This information would be related to my Registry membership being current; number of training hours completed; and/or status or completion of certain training, formal education or credentials as required by the State and/or ExceleRate.

Print Name: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If applicant is under the age of 18, a parent or legal guardian signature is required below.

Print Name: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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