Partnership for Children
(919)735-3371

Wayne County NC Pre-K Application

Application Date: _____ **School Yr. Applying for:** _____

CHILD and FAMILY INFORMATION

Child's Legal Name: Last	**First**	**Middle**
Child's Gender: □M □F **Date of Birth:**	**Preferred Name:**	
Name of Person(s) Child Lives With:	**Relationship to child:**	
Street Address:		
Mailing Address: (if different)		
City:	**State:**	**Zip Code:** **County:**
Primary Phone: □ Home □Message □ Cell □ Beeper/Pager ( ) -	**Alternate Phone:** □ Home □Message □ Cell □ Beeper/Pager ( ) -	
May we contact you by email? □ Yes □ No **Email address:** _____	**May we contact you by text messaging?** □ Yes □ No **Cell phone:** _____	

MEDICAL INFORMATION

Child's Doctor:	**Office Phone:**	**Address:**
Child's Dentist:	**Office Phone:**	**Address:**
Preferred Hospital:		
Please indicate which insurance this child currently receives? □ Medicaid □ NC Health Choice □ Tricare □ Private □ None		
If applicable, please list insurance number:	**Date Medicaid or NC Health Choice issued?**	

Which of the following relate to this child?

□ No significant health concerns
□ Behavior/Emotional Problems
□ Seizures/Convulsions
□ Chronic Health Problems (such as Asthma, Diabetes, Arthritis, Obesity)
□ Developmental Delays
□ Medically Fragile
□ Hyperactivity
□ Allergies _____
□ Rashes
□ Fears
□ Not yet potty trained
□ Other – please explain any items checked above: _____

List any medications child currently takes: _____

EMERGENCY CONTACTS/CHILD RELEASE INFORMATION

Please list emergency contacts and/or persons to whom this child may be released to (other than parent/guardian):

1	☐ *Contact*	**Name:**	**Address:**	**Phone: ( )**
	☐ *Release*	**Relationship:**	**City:**	**State: Zip:**
2	☐ *Contact*	**Name:**	**Address:**	**Phone: ( )**
	☐ *Release*	**Relationship:**	**City:**	**State: Zip:**
3	☐ *Contact*	**Name:**	**Address:**	**Phone: ( )**
	☐ *Release*	**Relationship:**	**City:**	**State: Zip:**
4	☐ *Contact*	**Name:**	**Address:**	**Phone: ( )**
	☐ *Release*	**Relationship:**	**City:**	**State: Zip:**
5	☐ *Contact*	**Name:**	**Address:**	**Phone: ( )**
	☐ *Release*	**Relationship:**	**City:**	**State: Zip:**
6	☐ *Contact*	**Name:**	**Address:**	**Phone: ( )**
	☐ *Release*	**Relationship:**	**City:**	**State: Zip:**

In the event of an emergency, I give my permission for provider to secure needed emergency medical care in the event that neither the family physician nor I can be contacted immediately. I further understand that emergency medical care may be obtained from the closest available emergency room facilities (usually Wayne Memorial Hospital), regardless of parent/guardian preference expressed to provider.

Parent/Guardian Signature: _____ **Date:** _____

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CHILD & FAMILY INFORMATION

Child's Race: □ Black /African American □ White □ American Indian/Alaska Native □ Pacific Islander/Native Hawaiian □ Asian □ Multi-Racial (please also check individual race boxes)

Parent's Race: □ Black/African American □ White □ American Indian/Alaska Native □ Pacific Islander/Native Hawaiian □ Asian □ Multi-Racial (please also check individual race boxes))

Child's Ethnicity: □ Hispanic or Latino origin (Cuban, Mexican, Puerto Rican, or other Spanish culture or origin) □ Non-Hispanic/Non-Latino origin

Primary Language spoken at home: □English □Spanish □Other (please indicate:)

Secondary Language spoken at home: □English □Spanish □Other (please indicate: _____)
Proficiency: □Poor □Moderate □Proficient

Family preference for written communication: □English □Spanish □Other (please indicate:)

Parental Status: □ One parent □ Two parent □ Foster □ Non-Parent □Other

Total Family Size? _____
□ Mother □Father □Number of Children_____ □ Other Adults (age 18+) How many?

Housing Status: □ Own home □Rent home/apartment/mobile home □Living with friends/relatives temporarily □Living in shelter □Living in hotel/motel □Other (explain)_____

Does your family receive assistance from any of the following? □ Work First Family Assistance □TANF □ SSI □ Food Stamps □ Medicaid through Work First □ Free/Reduced price School Meals

ADULT DEMOGRAPHIC INFORMATION

First and Last Name Enter Primary Adult First	**Date of Birth**	**Sex**	**Marital Status**	**(D1) Edu Level**	**(D2) Employ Status**	**(D3) Notes Name of Employer, Or Occupation**
		M F □ □				
		M F □ □				

Marital Status Codes
S - Single **M - Married**
D - Divorced **DS - Deployed Spouse**
Other _____

D1 – Education Level
G9 = Grade 9(or less) **GED** **AA** = Associates
G10 = Grade 10 **COL** = Some College **BA** = Bachelors
G11= Grade 11 **DRP** = Dropped out **MA** = Masters
STU = In High school **HSG** = High school Graduate

D2- Employment Status
U= Unemployed **T**= Student in School
F= Full Time work **P**= Part Time work
B= F-time & student **L**= P-Time & student
M=Medical Leave **R**= Retired/ Disabled
S= Seasonal work **Other** _____

If employed, how long has mother (or primary caregiver) been at current job?
□ < 90 days □ 3–12 months □ 13-18 months □ 19-24 months □ more than 2 years
If employed, how long has father (or secondary caregiver) been at current job?
□ < 90 days □ 3–12 months □ 13-18 months □ 19-24 months □ more than 2 years
If unemployed, are you currently looking for employment? □ yes □ no

CHILD DEMOGRAPHIC INFORMATION

First and last name of children in home	**Date of Birth**	**Sex**	**(D1) Related to**	**(D2) How Related**	**(D3) Notes** e.g., program participation status, other programs, etc.
C01 ---------**program applicant**----------	----------	------			
C02		M□F□			
C03		M□F□			
C04		M□F□			
C05		M□F□			
C06		M□F□			

(D1) Related to Codes
A01 - Primary Adult **A02** - Second Adult
B12 - Both Adults (includes step-parents)

(D2) How Related
C = Natural Child **F**= Foster Child
G = Grandchild **N**= Niece/Nephew

(D3) Participation Status Codes
A= Applied Child **Y**= Too Young
N= Next Yr. Elig. **O**= Too Old

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ADDITIONAL INFORMATION

Indicate which of the following agencies this child has previously received or currently receives services from:

□ None
□ Public Schools (List county, state_____)
□ Care Coordination for children (CC4C)
□ Children's Developmental Services Agency (formerly DEC)
□ Mental Health
□ Early Childhood Intervention
□ Other? _____

SPECIAL NEEDS INFORMATION

Does this child have a disability or special need? □Yes □ No □ Suspected

Comments: _____

If Yes, what is diagnosis: _____

Does child already have an IEP or IFSP? □Yes □ No

Is child receiving services related to disability? □ Yes □ No

Date IEP or IFSP initiated: _____

Please provide copies of IEP or referral paperwork to be added with your child's file.

If NO, has child been referred for services related to the suspected disability? □ Yes □ No

If Yes, who has child been referred to?

SITE PREFERENCE INFORMATION

(Please note that transportation and extended day services are not available nor guaranteed at all sites)

What is your site preference? (Please **numbe**r 1-4 your first four choices with 1 indicating most desired to 4 being least desired)

You are applying for the NC Pre-K Program. While we do request your site preferences, placement is not guaranteed.

***North Carolina Pre-K* sites:**

____ Brogden Primary School
____ Eastern Wayne Elementary
____ Carver Elementary (Mt. Olive)
____ Meadow Lane Elementary
____Spring Creek Elementary
____ Wee are the World Child Care (Dudley) (3)
____ Bright Beginnings Child Care/Preschool (2)
____ Fremont Stars Elementary
____ North Drive Elementary
____ School Street Elementary (2)
____ Small World Child Care/Preschool (6)
____ WAGES Carver (Mt. Olive) (1)
____ Bright Beginnings II
____ Happy Days Child Care/Preschool (2)
____ Northeast Elementary
____ Rosewood Elementary
____ Tommy's Road Elementary
____ WAGES Royall Avenue (3)

Is child currently in childcare or other pre-K setting? □ Yes □ No If yes, where: _____ how long? _____

Has child ever been in childcare or other pre-K setting? □ Yes □ No If yes, where: _____ How long? _____

Does this child currently receive subsidy assistance for childcare services? □ Yes □ No

If No, is child/family currently on subsidy waiting list? □ Yes □ No

TRANSPORTATION INFORMATION

(Transportation for North Carolina Pre-K students is currently provided by WAGES Head Start and Wee Are the World on a very limited basis)

Will transportation services be needed? □ Yes □ No

If Yes, list Pick-up Location: _____

list Drop-off Location: _____

Wee are the World offers transportation services at a cost and on a limited basis ONLY. Transportation services not guaranteed.

If transportation is not available, would you be able to get your child to and from school on a daily basis?

□ Yes □ No Parent Initials: _____

EXTENDED DAY CHILD CARE INFORMATION:

Available at a cost to be decided by the NC Pre-K Site Director – contact the site for specific cost information

Will extended day childcare services be required for this child? (WCPS sites does not provide extended day) □ Yes □ No

If Yes, check all that apply: □Before School Care □ After School Care □ Holiday Care □ Summer Care

Does family have alternative arrangements if extended day childcare services cannot be provided? □ Yes □ No

If Yes, with whom:

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INCOME VERIFICATION DOCUMENTATION AND ELIGIBILITY

To be completed by NC Pre-K Contract Administrator ONLY

Based on Review of the following Income Verification:

____Current Pay Stub(s) ____ W-2 ____Income Tax Form(s) ____Child Support ____Statement from Employer ____Statement from DSS ____ Income Verification Statement ____ Other: _____

This child is considered: _____ELIGIBLE _____INELIGIBLE for NC Pre-K

Verification Completed by: _____

Reviewed by: _____

PARENT/GUARDIAN - PLEASE READ AND SIGN

I understand that this is an application for services offered and does not constitute enrollment into any program. I certify that the information given on this application is true and accurate and all income has been reported. I understand that this information is being given for the receipt of state funds; that officials may verify the information on this application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable federal and/or state laws.

The information on this form may be used only in the determination of eligibility for the North Carolina Pre-K program. I understand that I will be releasing information that will show that I am applying for my child to be considered for either program. Program administration may verify information on this form with all entities as reported (including Exceptional Children's Program, Wayne County Health Department, etc.). I give up my rights to confidentiality for these purposes only.

I understand that if my child is selected to participate in the program, parent involvement will be critical to the success of my child. I/we will commit to participate as required by the program criteria. I also understand that, unless already completed on a current physical, my child may receive hearing and vision screenings at the placement site. Ultimately, it is my responsibility as a parent to ensure screenings are completed.

I agree to allow any and all documents pertaining to my child's enrollment of the program to be shared among collaborating agencies as necessary for my child's care.

I certify that I am the parent/guardian of the child for whom this application is being made. If requested, all information regarding the child will be provided to both parents/guardians unless legal documentation states otherwise.

_____ _____

Parent (Primary Caregiver) Signature (required) **Date**

_____ _____

Parent (Secondary Caregiver) Signature (if available) **Date**

Verifications:

❑ **Child's Birth Certificate (Certificate, Medical, Family Bible)**	❑ **Food Stamp Card, if applicable**
❑ **Child's Medicaid card or Private Insurance card**	❑ **Proof of Income (current pay stub, LES, child support, other)** ❑ **For Head Start/Early Head Start Only – need verification for previous 12 months (Acceptable verification includes: W-2 forms, tax returns, original pay stubs, letter from employer, or letter from DSS)**
❑ **Child's Immunization Record**	❑ **AFDC/TANF (Letter stating award of money received), if applicable**
For Office Use only: ❑ **Physical Date: _____ H _____ V_____**	❑ **Verification of child's special needs if applicable (Complete and current IEP, Medical Records, Letter from appropriate organization)**
❑ **Dental Screening: Date_____**	❑ **Other**