



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: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Home () - <input type="checkbox"/> Work <input type="checkbox"/> Cell			Alternate Phone: <input type="checkbox"/> Home () - <input type="checkbox"/> Work <input type="checkbox"/> Cell		
Email address: _____					

MEDICAL INFORMATION

Child's Doctor:		Office Phone:		Address:	
Child's Dentist:		Office Phone:		Address:	
Preferred Hospital:					
Please indicate which insurance this child currently receives? <input type="checkbox"/> Medicaid <input type="checkbox"/> NC Health Choice <input type="checkbox"/> Tricare <input type="checkbox"/> Private <input type="checkbox"/> None					
If applicable, please list insurance number:				Date Medicaid or NC Health Choice issued?	
Which of the following relate to this child?					
<input type="checkbox"/> No significant health concerns		<input type="checkbox"/> Developmental Delays		<input type="checkbox"/> Allergies _____	
<input type="checkbox"/> Behavior/Emotional Problems		<input type="checkbox"/> Medically Fragile		<input type="checkbox"/> Rashes	
<input type="checkbox"/> Seizures/Convulsions		<input type="checkbox"/> Hyperactivity		<input type="checkbox"/> Fears	
<input type="checkbox"/> Chronic Health Problems (such as Asthma, Diabetes, Arthritis, Obesity)				<input type="checkbox"/> Not yet potty trained	
<input type="checkbox"/> Other – please explain any items checked above: _____					
List any medications child currently takes: _____					
An Action Plan must be included to instruct staff on how to respond to medical emergencies (including emergencies related to: seizure, allergic reactions, diabetes, asthma, etc.)					

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	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()	
	<input type="checkbox"/> Release	Relationship:	City:	State:	Zip:
2	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()	
	<input type="checkbox"/> Release	Relationship:	City:	State:	Zip:
3	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()	
	<input type="checkbox"/> Release	Relationship:	City:	State:	Zip:
4	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()	
	<input type="checkbox"/> Release	Relationship:	City:	State:	Zip:
5	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()	
	<input type="checkbox"/> 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 UNC Health), 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 Kinship 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	Notes Name of Employer, Or Occupation
		M F				
		M F				

<u>Marital Status Codes</u>	<u>D1 – Education Level</u>	<u>D2- Employment Status</u>
S - Single M - Married D - Divorced SP - Separated Other _____	G9 = Grade 9(or less) GED G10 = Grade 10 COL = Some College BA = Bachelors G11= Grade 11 DRP = Dropped out MA = Masters STU = In High school HSG = High school Graduate	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 unemployed, are you currently looking for employment? yes no

CHILD DEMOGRAPHIC INFORMATION

First and last name of children in home	Date of Birth	Sex	Schools siblings attend (child care, elementary, middle, high, etc.)
C01		M F	
C02		M F	
C03		M F	
C04		M F	
C05		M F	
C06		M F	



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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 _____)
- Mental Health
- Care Management for At-risk Children (CMARC)
- Children's Developmental Services Agency
- 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? Yes No
Is child receiving services related to disability? Yes No
Date IEP initiated: _____

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

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

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 number 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. The Partnership for Children has the authority to re-evaluate and/or modify your child's placement during participation if need arises.
***Number of available classrooms are listed beside site name.

North Carolina Pre-K sites:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bright Beginnings Site 1 (2) | <input type="checkbox"/> Bright Beginnings Site 2 (2) (Hwy 111) | <input type="checkbox"/> Brogden Primary (1) |
| <input type="checkbox"/> Carver Elementary (1) | <input type="checkbox"/> Carver Head Start (3) | <input type="checkbox"/> Wee are the World 2 (1) (Goldsboro) |
| <input type="checkbox"/> Wee are the World (Dudley) (4) | <input type="checkbox"/> Eastern Wayne Elementary (2) | <input type="checkbox"/> Fremont Stars (1) |
| <input type="checkbox"/> Little Warriors Christian Aca. (1) | <input type="checkbox"/> Meadow Lane Elementary (1) | <input type="checkbox"/> Northeast Elementary (1) |
| <input type="checkbox"/> North Drive Elementary (1) | <input type="checkbox"/> Rosewood Elementary (1) | <input type="checkbox"/> Royall Avenue Head Start (4) |
| <input type="checkbox"/> Tommy's Road Elementary (1) | <input type="checkbox"/> Small World Child Care (6) | <input type="checkbox"/> Spring Creek Elementary (1) |

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 and WAGES 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 AND PUBLIC ASSISTANCE) VERIFICATION DOCUMENTATION AND ELIGIBILITY

To be completed by NC Pre-K Contract Administrator ONLY

Based on Review of the following Income Verification and Public Assistance (check documents submitted)

_____ *Tax Records (W-2's; 1040 – line 7) or Schedule C Profit or Loss from Business, line 7 Gross Income minus 20% (self-employed)*

_____ *One month's worth of pay stubs (if weekly pay – 4 stubs, if biweekly or bimonthly – 2 stubs, if monthly – one month)*

_____ *Award letters from the Social Security Administration*

_____ *Award letters from the Employment Security Commission/ Unemployment*

_____ *Award letters from the Veteran Affairs*

_____ *Employer written statements*

_____ *Child support documentation*

_____ *Signed statements when the individual claims to have no verifiable countable income*

_____ *Guardianship/custody documentation*

_____ *Experiencing Homelessness*

_____ *In Foster Care*

_____ *Receiving refugee services*

_____ *WIC*

_____ *Public Housing*

_____ *TANF/Work First*

_____ *Medicaid*

_____ *SSI*

_____ *Food and Nutrition Services (Food Stamps)*

_____ *SNAP*

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.

NC Pre-K Program Requirements mandate that the following be completed within 30 days after a child enters the NC Pre-K Program: Physical Examination, includes hearing, vision, and dental screening, and current immunization. If your child does not have the necessary hearing and vision screenings noted on the physical prior to placement, your child may be screened at the facility. These screenings are not guaranteed; it is your responsibility to secure screenings for your child in order to meet this state mandate. Developmental and Social/Emotional Screenings will be completed within the first 90 days of enrollment.

I understand that my child may be deemed "eligible" for the program, but may be placed on the waiting list since there are more applicants than available slots.

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,



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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