



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"/> Message () - <input type="checkbox"/> Cell <input type="checkbox"/> Beeper/Pager		Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Message () - <input type="checkbox"/> Cell <input type="checkbox"/> Beeper/Pager	
May we contact you by email? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we contact you by text messaging? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email address: _____		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? <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"/> Behavior/Emotional Problems <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Chronic Health Problems (such as Asthma, Diabetes, Arthritis, Obesity) <input type="checkbox"/> Other – please explain any items checked above: _____ <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Medically Fragile <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Allergies _____ <input type="checkbox"/> Rashes <input type="checkbox"/> Fears <input type="checkbox"/> Not yet potty trained		
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:
	<input type="checkbox"/> Release	Relationship:	City:
2	<input type="checkbox"/> Contact	Name:	Address:
	<input type="checkbox"/> Release	Relationship:	City:
3	<input type="checkbox"/> Contact	Name:	Address:
	<input type="checkbox"/> Release	Relationship:	City:
4	<input type="checkbox"/> Contact	Name:	Address:
	<input type="checkbox"/> Release	Relationship:	City:
5	<input type="checkbox"/> Contact	Name:	Address:
	<input type="checkbox"/> Release	Relationship:	City:
			Phone: ()
			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: <input type="checkbox"/> Black /African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial (please also check individual race boxes)
Parent's Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial (please also check individual race boxes)
Child's Ethnicity: <input type="checkbox"/> Hispanic or Latino origin (Cuban, Mexican, Puerto Rican, or other Spanish culture or origin) <input type="checkbox"/> Non-Hispanic/Non-Latino origin
Primary Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please indicate: _____)
Secondary Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please indicate: _____)
Proficiency: <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Family preference for written communication: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please indicate: _____)
Parental Status: <input type="checkbox"/> One parent <input type="checkbox"/> Two parent <input type="checkbox"/> Foster <input type="checkbox"/> Non-Parent <input type="checkbox"/> Other
Total Family Size? _____ <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Number of Children <input type="checkbox"/> 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? <input type="checkbox"/> Work First Family Assistance <input type="checkbox"/> TANF <input type="checkbox"/> SSI <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medicaid through Work First <input type="checkbox"/> 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 G10 = Grade 10 COL = Some College G11 = Grade 11 DRP = Dropped out 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 _____
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If employed, how long has mother (or primary caregiver) been at current job? <input type="checkbox"/> < 90 days <input type="checkbox"/> 3-12 months <input type="checkbox"/> 13-18 months <input type="checkbox"/> 19-24 months <input type="checkbox"/> more than 2 years
If employed, how long has father (or secondary caregiver) been at current job? <input type="checkbox"/> < 90 days <input type="checkbox"/> 3-12 months <input type="checkbox"/> 13-18 months <input type="checkbox"/> 19-24 months <input type="checkbox"/> more than 2 years
If unemployed, are you currently looking for employment? <input type="checkbox"/> yes <input type="checkbox"/> no

CHILD DEMOGRAPHIC INFORMATION

First and last name of children in home	Date of Birth	Sex	(D1) Related to	(D2) How Related	(D3) Schools siblings attend (child care, elementary, middle, high, 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 Care Coordination for children (CC4C)
 Public Schools (List county, state _____) 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 **If NO, has child been referred for services related to the suspected disability?** Yes No

Is child receiving services related to disability? Yes No If Yes, who has child been referred to? _____

Date IEP or IFSP initiated: _____

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.
 ***Number of available classrooms are listed beside site name if more than one classroom is available.

North Carolina Pre-K sites:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bright Beginnings (2) | <input type="checkbox"/> Bright Beginnings Site 2 (Hwy 111) | <input type="checkbox"/> Brogden Primary |
| <input type="checkbox"/> Carver Elementary | <input type="checkbox"/> Carver Head Start (2) | <input type="checkbox"/> Dillard Academy |
| <input type="checkbox"/> Eastern Wayne Elementary | <input type="checkbox"/> Fremont Stars | <input type="checkbox"/> Happy Days Child Care (2) |
| <input type="checkbox"/> Meadow Lane Elementary | <input type="checkbox"/> Northeast Elementary | <input type="checkbox"/> North Drive Elementary |
| <input type="checkbox"/> Rosewood Elementary | <input type="checkbox"/> Royall Avenue Head Start (2) | <input type="checkbox"/> School Street Early Learning Ctr. (2) |
| <input type="checkbox"/> Small World Child Care (6) | <input type="checkbox"/> Spring Creek Elementary | <input type="checkbox"/> Tommy's Road Elementary |
| <input type="checkbox"/> Wee are the World (Dudley) (4) | | |

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 VERIFICATION DOCUMENTATION AND ELIGIBILITY

To be completed by NC Pre-K Contract Administrator ONLY

Based on Review of the following Income Verification (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*

_____ *Employer written statements*

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

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 is 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, 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:

<input type="checkbox"/> Child's Birth Certificate (Certificate, Medical, Family Bible)	<input type="checkbox"/> Proof of Income (current pay stub, LES, child support, other)
<input type="checkbox"/> Child's Medicaid card or Private Insurance card	<input type="checkbox"/> Verification of child's special needs if applicable (Complete and current IEP, Medical Records, Action Plan, Letter from appropriate organization)
<input type="checkbox"/> Child's Immunization Record	<input type="checkbox"/> Documentation of Homelessness (if applicable)
<input type="checkbox"/> Physical Date: _____ H _____ V _____ D _____	<input type="checkbox"/> Other: