2020-2022

NASH/EDGECOMBE PRE-K APPLICATION FORM

To participate in these pre-kindergarten programs your child must be four years old on or before August 31st of the current program year and must meet one or more of the following requirements:

- Family's gross income is at or below 75% of the State Median Income level
- Child has an identified developmental disability
- Child has Limited English Proficiency (LEP) as indicated by the family and/or child speaking limited or no English in the home
- Child has an educational need as indicated by the child's performance results on an approved developmental screening or in an existing Individualized Education Plan (IEP)
- Child has a chronic health condition as indicated by the diagnosis from a professional health care provider
- Child and family are identified as homeless
- Child is a member of an eligible military family

*****Determination of eligibility does not guarantee a placement in a pre-k program. Placement is also determined by availability of funds*****

Please complete the FULL application and include the following attachments:

- ❑ Certified Birth Certificate
- ❑ 30 consecutive days of paystubs for the child's parents/guardians or a completed wage form signed by the employer (pay information must be no more than two months prior to the date on the application)
- ❑ Copy of most recent health assessment/well-child visit report
- ❑ Written documentation of any other sources of income: Social Security (SSA), SSI Disability, Child Support, etc.
- ❑ Copy of current immunization record
- ❑ Two (2) proofs of Residence (Ex. current utility bill, (gas, water, lights only), lease agreement, mortgage or property tax, driver's license)

Pre-K is available in a variety of settings in Nash and Edgecombe counties, including private child care centers, Head Start, and public schools. The following is a list of Pre-K providers for 2020-2022 – Please review the list and select your first, second, and third site choices.

- **Apple Tree Wee School** – Rocky Mount
- **AJ Richardson Head Start** – Rocky Mount
- **Old Carriage Road Head Start** – Rocky Mount
- **Edgecombe County Public Schools**
- **Nash-Rocky Mount Public Schools**
- **Foundation Builders Academy** – Rocky Mount
- **Joyland Preschool** – Nashville
- **Little Grown Ups Child Care** – Battleboro
- **St. Stephen's Loving Daycare** – Rocky Mount
- **Stepping Stone Preschool and Child Care** – Nashville
- **Think and Grow Child Care Center #3** – Tarboro

1st Choice: _____ 2nd **Choice:** _____ 3rd **Choice:** _____

Please review all information to ensure you have filled out the form completely. You must sign below.

The Early Care & Education programs and agencies that may receive a copy of this form include:

- The Down East Partnership for Children
- Nash/Edgecombe NC Pre-Kindergarten Programs
- Nash/Edgecombe Public School Pre-Kindergarten Programs
- N.E.E.D, Inc. - Head Start

I give permission for my child to be assessed and referred to the Early Care & Education programs and agencies listed above, by forwarding to the appropriate program a copy of this form and any other necessary information. Representatives from any of the indicated Early Care & Education programs and agencies have my permission to confirm all of the information on this form.

I understand that additional information may be requested after my eligibility for a particular program has been determined.

I certify that all of the information above is subject to verification, is true and correct and that all income is reported to the best of my ability.

Signature of Parent/Guardian completing this form: _____ **Date:** _____

If not the parent, official guardianship documentation may be required.

PARENT/GUARDIAN INFORMATION

FIRST PARENT/GUARDIAN – *Child must be living in the same household as the person(s) listed below.*

Parent/Guardian Name: _____

Relationship to Child: ❑ Mother ❑ Father ❑ Grandparent ❑ Guardian/Custodian ❑ Other:_____

Home Address: *(Please include zip)* _____ _____

Mailing Address: *(If different than home – Please include zip)* _____ _____

County You Live In: ❑Nash ❑ Edgecombe ❑ Other _____

Phone Number: _____

Second Phone Number: _____

Email address: _____

Ethnicity: Are you of Latino/Hispanic descent? ❑ Yes ❑ No

Race: *(please check all that apply)* ❑ White ❑ Black ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employment/School Status: *(please check all that apply)* ❑ Employed/Self-Employed** ❑ Unemployed ❑ Seeking Employment ❑ Attending Job Training ❑ Attending High School/GED ❑ Attending College

Paycheck Received: ❑ Weekly ❑ Bi-Weekly ❑ Semi- Monthly ❑ Monthly

*** If you are employed you must provide 30 days of pay stubs or have your employer complete the attached wage form.***

****Self-employed individuals may submit W-2 tax form from previous year.***

Is there another parent or guardian that lives in the home with the child? ❑ YES ❑ NO

If there is not a second parent in the home you must mark "NO" to avoid having an incomplete application

SECOND PARENT/GUARDIAN - *You must complete information for each parent in the household.*

Parent/Guardian Name: _____

Relationship to Child: ❑ Mother ❑ Father ❑ Grandparent ❑ Guardian/Custodian ❑ Other:_____

Ethnicity: Are you of Latino/Hispanic descent? ❑ Yes ❑ No

Race: *(please check all that apply)* ❑ White ❑ Black ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employment/School Status: *(please check all that apply)* ❑ Employed/Self-Employed** ❑ Unemployed ❑ Seeking Employment ❑ Attending Job Training ❑ Attending High School/GED ❑ Attending College

Paycheck Received: ❑ Weekly ❑ Bi-Weekly ❑ Semi- Monthly ❑ Monthly

*** If you are employed you must provide 30 days of pay stubs or have your employer complete the attached wage form.***

****Self-employed individuals may submit W-2 tax form from previous year.***

PARENT/GUARDIAN MILITARY STATUS

Does this child have a parent/guardian who is an active duty member of the military? ❑ Yes ❑ No

Does this child have a parent/guardian who was ordered to active duty in the past 18 months or expected to be ordered within the next 18 months or injured and/or is receiving military disability retirement or was killed while serving on active military duty? ❑ Yes ❑ No

CHILD INFORMATION

Please complete information for each child that needs Pre-K services.

CHILD #1

Child's Full Name:
(*as on birth certificate*) _____

Child's Date of Birth: _____

Child's Gender: ❑ Male ❑ Female

Child's Ethnicity: **Is child of Latino/Hispanic descent?** ❑ Yes ❑ No

Child's Race: ❑ White ❑ Black ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____
(please check all that apply)

Family Status: *(check one only)*
Who does the child live with?
❑ Mother ❑ Father ❑ Mother & Father
❑ Legal Guardian/Custodian
❑ Other: _____

CHILD CARE INFORMATION

Who cares for child if you work or go to school?

❑ Enrolled in a child care facility (center or home)
Name of facility: _____
❑ Previously/no longer enrolled in a child care facility
❑ Child cared for by friend, neighbor, or family member
❑ Parent stays home with child

Do you receive assistance paying for your child care?

❑ Receiving assistance with child care from:
❑ DEPC Scholarship Program
❑ Department of Social Services
❑ NEED/Head Start
❑ Other: _____
❑ Not receiving assistance with child care (I pay full cost)

SPECIAL NEEDS AND SERVICES

Does your child have a developmental or educational challenge? ❑ Yes ❑ No ❑ Don't know
If yes, please explain and attach appropriate documentation: _____

Does your child have a physical challenge or chronic illness? ❑ YES ❑ NO
If yes, please explain and attach appropriate documentation: _____

Does your child have an Individualized Education Plan (IEP)? ❑ YES ❑ NO ❑ Don't know

CHILD #2

Child's Full Name:
(*as on birth certificate*) _____

Child's Date of Birth: _____

Child's Gender: ❑ Male ❑ Female

Child's Ethnicity: **Is child of Latino/Hispanic descent?** ❑ Yes ❑ No

Child's Race: ❑ White ❑ Black ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____
(please check all that apply)

Family Status: *(check one only)*
Who does the child live with?
❑ Mother ❑ Father ❑ Mother & Father
❑ Legal Guardian/Custodian
❑ Other: _____

CHILD CARE INFORMATION

Who cares for child if you work or go to school?

❑ Enrolled in a child care facility (center or home)
Name of facility: _____
❑ Previously/no longer enrolled in a child care facility
❑ Child cared for by friend, neighbor, or family member
❑ Parent stays home with child

Do you receive assistance paying for your child care?

❑ Receiving assistance with child care from:
❑ DEPC Scholarship Program
❑ Department of Social Services
❑ NEED/Head Start
❑ Other: _____
❑ Not receiving assistance with child care (I pay full cost)

SPECIAL NEEDS AND SERVICES

Does your child have a developmental or educational challenge? ❑ Yes ❑ No ❑ Don't know
If yes, please explain and attach appropriate documentation: _____

Does your child have a physical challenge or chronic illness? ❑ YES ❑ NO
If yes, please explain and attach appropriate documentation: _____

Does your child have an Individualized Education Plan (IEP)? ❑ YES ❑ NO ❑ Don't know

ADDITIONAL INCOME INFORMATION

List the amounts of the following income sources that you receive - write in $0 if none is received.

Veteran's Benefits:	$_____per month	Unemployment Benefits:	$_____ per month
Social Security (SSA):	$_____per month	Workers' Compensation:	$_____ per month
SSI Disability:	$_____per month	Other: _____	$_____ per month
Child Support:	$_____per month	Other: _____	$_____ per month

You must provide written documentation for all additional income sources

HOUSEHOLD INFORMATION

Please list <u>EVERY</u> person living at the home address reported on this application, including the child*

Name	Date of Birth	Relationship to Child
Example: Jane Smith	*01/01/1988*	*Mother*

Total number of family members in the home (including child): _____

What language is spoken in the home most of the time?

❑ English ❑ Spanish ❑ Arabic ❑ Chinese ❑ Hindi ❑ Vietnamese ❑ Other: _____ (please specify)

Which best describes your family's current living situation:

❑ Permanent
❑ Homeless or Emergency Homeless Shelter
❑ Battered Women and Children Shelter
❑ Living with friend/family member due to loss of housing
❑ Hotel/Motel
❑ Hospital for 30 days or under
❑ Lack permanent nighttime address

WAGE FORM

NASH/EDGECOMBE PRE-K APPLICATION

In order to determine eligibility for Nash/Edgecombe pre-kindergarten services it is necessary for you to provide proof of income.

****If you do not have paystubs**, please have your **current employer complete and sign** the following form. Please list gross wages for 30 days prior to the current month. Please complete for **each** parent/guardian.

PARENT/GUARDIAN #1: _____

Employer Name: _____ **Employer Phone #:** _____

Paycheck received: ❑ Once per week ❑ Every two weeks ❑ Twice per month (ex. 1st & 15th) ❑ Once per Month

Please complete using information from the last 30 days – Please Include Overtime

Pay Period	Gross Pay (BEFORE deductions)	Regular Pay	Overtime Pay (IF applicable)
Example: 5/12/19 – 5/25/19	**$1,234.56**	**$1,000.00**	**$234.56**

Employer's Signature: _____ **Date:** _____

Employer/Company: _____

PARENT/GUARDIAN #2: _____

Employer Name: _____ **Employer Phone #:** _____

Paycheck received: ❑ Once per week ❑ Every two weeks ❑ Twice per month (ex. 1st & 15th) ❑ Once per Month

Please complete using information from the last 30 days – Please Include Overtime

Pay Period	Gross Pay (BEFORE deductions)	Regular Pay	Overtime Pay (IF applicable)
Example: 5/12/19 – 5/25/19	**$1,234.56**	**$1,000.00**	**$234.56**

Employer's Signature: _____ **Date:** _____

Employer/Company: _____

(Intentionally Blank)

NASH/EDGECOMBE
PRE-KINDERGARTEN HEALTH ASSESSMENT REPORT

PARENT COMPLETE

Personal Data **Please bring your child's shot records with you to this visit**

Please Print Clearly – See other side for more required information. Please present completed form to your child's school.

Child's Name: _____ _____ _____ **Birth Date:** ____/____/ 20____ (mm/dd/yyyy)
(Last) (First) (Middle)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Yes	No	
☐	☐	Are you concerned about your child's health, weight, development, or behavior?
☐	☐	Does anyone in your family have a condition that has affected their health, weight, development, or behavior? **(Please explain in the comments section)**
☐	☐	Has your child been seen by a provider for any health, weight, development, or behavior concern?
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

_____

Parent/Guardian Name: _____ **Phone:** _____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC. **Signature:** _____ **Date:** _____

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

☐ **No Recommendations, Concerns, or Needs** ☐ **Requesting School Follow Up**

☐ **Medication**

☐ Child takes medication for specific health conditions List Medications: 1. _____ 3. _____

☐ Medication must be given and/or available at school 2. _____ 4. _____

☐ **Allergy**

☐ Food: _____ ☐ Insect: _____ ☐ Medicine: _____ ☐ Other: _____

Type of allergic reaction: ☐ Anaphylaxis ☐ Local Reaction **Response Required:** ☐ Epinephrine Auto-Injector ☐ Other: _____ ☐ None

☐ **Developmental Concerns Identified –** Child needs referral to school support team for further evaluation. **(See comments below)**

☐ **Special Diet**

Guidance: _____

☐ **Health-Related Recommendations to Enhance School Performance (***For example: sitting near the front of classroom, special equipment needs).*

Please specify: _____

☐ **School Health Forms Attached**

☐ School Medication Authorization Form ☐ Diabetes Care Plan ☐ Asthma Action Plan ☐ Health Care Plan(s) List Condition _____

Comments: _____

_____

Was this assessment completed in the child's regular health care provider's office? ☐ ***Yes*** ☐ ***No***

<u>If no</u>, please provide a copy to the child's parent to give to the child's regular health care provider.

Health Care Professional's Certification – Attach a copy of the immunization record. Complete ALL screenings.

I certify that the information on this form is accurate and complete to the best of my knowledge.

<u>Provider Stamp Here</u>

Provider's Name: _____

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice Phone: _____ Fax: _____

PARENT

Personal Data

Child's Birth Date: ____/____/ 20____ (mm/dd/yyyy)

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

County of Residence: _____ **Zip Code:** _____

School your child will be attending: _____ **Sex:** ☐ 1 Male ☐ 2 Female **Hispanic or Latino Origin:** ☐ 1 Yes ☐ 2 No

Child has: ☐ 1 Medicaid ☐ 2 Private Insurance/HMO ☐ 3 No Insurance ☐ 4 Other: _____

Place where your child gets regular health care:
☐ 1 Health Department ☐ 2 Hospital Clinic ☐ 3 Community Health Center ☐ 4 Private Doctor/HMO ☐ 5 Other: _____ ☐ 6 No regular place

Doctor/Practice Name: _____ **Dentist Name:** _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: ____/____/____ - Assessment must be completed no more than 12 months prior to child's first day of Pre-K

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Immunizations – Attach a copy of the immunization record.

Pertinent Illnesses, Risks or Developmental Problems: (Please check all that apply)

☐ Allergy
☐ Anemia ☐ At-Risk for Anemia
☐ Asthma
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorders
☐ Lead (Hx of >10 mcg/dL) ☐ At-Risk ☐ Test Done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other:_____
☐ None

Screening Results – Screenings MUST be completed and scored for ALL children who may be enrolling in an NC Pre-K program.

Developmental

Screening Tool(s) Used: ☐ 1 PEDS ☐ 4 PSC ☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern Identified 2	Referred to Specialist 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Comments: _____

_____

Hearing

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.

Screening Tool Used: ☐ 1 OAE ☐ 2 Audiometry

☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.
☐ 3 Referral to audiologist/ENT **(check if YES)**
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	Right	Left	Stereopsis ☐ Pass ☐ Fail
Far:	20/	20/	Acuity Test Used:

Was test performed with corrective lenses? ☐ Yes ☐ No

☐ 1 Pass (Acuity, Stereopsis, & Symptoms)
☐ 2 Referral to eye doctor **(check if YES)** Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease.
☐ 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.

Physical Examination

Weight: _____ lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI) – for age: _____
☐ 1 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to < 85%ile)
☐ 3 Overweight (85%ile to < 95%ile)
☐ 4 Obese (>95%ile)

Blood Pressure: _____/_____
☐ 1 Within Normal Range
☐ 2 >90th percentile (_____%ile)

	Normal 1	Abnormal 2
HEENT	☐	☐
Dental/Oral	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurological	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

Comments: _____

_____

_____

_____