Arkansas Better Chance Program

P.O. Box 1437, Slot S-160

Little Rock, Arkansas 72203

Child Application

Agency Quality Child Care		**Applicant For**	☐ **Current Year** ☐ **Next Year**
Center	QCC FS	**Address** 2015 S. Savannah St. Ft. Smith, AR 72901	**Phone** 479-646-3479

First Name		**M. Initial**	**Last Name**		
Application Date **mm-dd-yyyy**	/ /	**Gender**	☐ **Male** ☐ **Female**	***Birth Date** **mm-dd-yyyy**	/ /

Demographic Information

***Primary Language**		**Other Language**	
Speak English at home?	☐ Yes ☐ No	**English Skills**	☐ Very Well ☐ Well ☐ Not Well ☐ Not At All

***Ethnicity**	***Race**		
☐ Hispanic	☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Yes, Cuban	☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Yes, Mexican, Mexican American, Chicano	☐ Immigrant	☐ Japanese	☐ Korean
☐ Yes, Other Spanish, Hispanic, Latino	☐ Migrant	☐ Multi-Racial	☐ Native Hawaiian
☐ Yes, Puerto Rican	☐ Other	☐ Other Asian	☐ Other, Pacific Islander
	☐ Samoan	☐ Unknown	☐ Vietnamese
	☐ White		

SSN	**Other ID**	**US Citizen** ☐ Yes ☐ No

Eligibility Information

***Parental Status**

◯ Two Parent ◯ Single Parent

☐ Teen Parent	☐ Disabled Parent	☐ Foster Parent	☐ Active Male
☐ Homeless	☐ Guardian	☐ Group Home	☐ Dual Custody
☐ Student Parent	☐ Migrant Parent	☐ Grand Parent	

Previously in Foster Care

Relation to Primary Caregiver

Relation to Secondary Caregiver

Additional Eligibility Information	
Special Need	**Disability Status** No Suspected Certified IEP Certified IFSP
Child Protective Services	**Non-English Speaking/LEP**
Incarcerated Parent	
Non-parental custody/not living with Mother/Father	**Active Duty**
Arrested/Convicted of Drug Offense	**Completed H3**
No HS Diploma	**Completed H4**
Waiver	**Completed H5**
Low Birth Weight	**Enrolled in HIPPY Year 1**
Parent < 18 yrs. of age at birth	**Enrolled in HIPPY Year 2**
Substance Abuse/Addiction	**Enrolled in HIPPY Year 3**
History of Abuse/Neglect/Victim	
Parents cannot read	
Title I	
IDEA	
Developmental Delay	
Additional Points (Agency use only)	

Program Information		
***Program Model (Agency use only)**	***Program Options (Agency use only)**	**Hours Per Day**

Other Information	
*Full-Year Needed	*Full-Day Needed
* Child is receiving a childcare subsidy (Voucher or Contracted slot)	

*Father/father figure participates in regularly scheduled activities designed for involvement in HS or EHS.	
Child has a medical card	
***Secondary Source of Child Care**	None; Family Child Care Home; Child Care Center or Classroom; Home or Another Home with a Relative or Unrelated Adult; Public School pre-Kindergarten Program; Other
Current School District (where child resides)	
*Did child receive services before classes began in the current School Year?	Yes; No

USDA Information		
USDA Enrollment Date	**USDA Expiration Date**	**USDA/CACFP Income**

Additional Needs & Services

Child Needs

Full Time Care; Part Time Care; Evening; Overnight; Weekend

Enrolled but Waiting (for transition):

Head Start; CDD Center or FCCHEN; State Preschool; AP Program; CDE After-school; Other

Previously served and seeking to return

Comments

Signature: ______________________	Signature: ______________________
Date: ______________________	Date: ______________________

Fields marked with (*) are required for PIR report

Arkansas Better Chance Program

P.O. Box 1437, Slot S-160

Little Rock, Arkansas 72203

Family Eligibility Application

Enrolling Agency	Quality Child Care	**Enrolling Site**	QCC FS 2015 S. Savannah Ft. Smith, AR 72901

Primary Caregiver General Information

First Name		**M. Initial**		**Last Name**	
Gender	☐ Male ☐ Female	***Application Date**	mm-dd-yyyy / /	***Birth Date**	mm-dd-yyyy / /
SSN		**TANF #**	**Receiving WIC**	☐ Yes ☐ No ☐ Previously	**DCFS** ☐
***Language**		***Other Language**			***Food Stamp / SNAP** ☐ Yes ☐ No

***Ethnicity**	***Race**		
☐ Hispanic	☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Yes, Cuban	☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Yes, Mexican, Mexican American, Chicano	☐ Immigrant	☐ Japanese	☐ Korean
☐ Yes, Other Spanish, Hispanic, Latino	☐ Migrant	☐ Multi-Racial	☐ Native Hawaiian
☐ Yes, Puerto Rican	☐ Other	☐ Other Asian	☐ Other, Pacific Islander
	☐ Samoan	☐ Unknown	☐ Vietnamese
	☐ White		

Education Level		**Employment Status**	
	☐ Bachelor or Advanced Degree		☐ Farmer
	☐ College degree or training school certificate		☐ Full-time & training
	☐ ESL		☐ Employed full-time
	☐ GED		☐ Homemaker
	☐ Grade 10		☐ Job training/school(part-time)
	☐ Grade 11		☐ Migrant Farm worker
	☐ Grade 12		☐ Part-time & training
			☐ Employed part-time

<table>
<tr><td></td><td>☐ Grade 9 or less
☐ High School Graduate
☐ No High School
☐ Some College/ Vocational/Associates Degree
☐ Some High School
☐ Unknown</td><td></td><td>☐ Retired or disabled
☐ Job training or in school
☐ Employed seasonal
☐ Seasonal Farm worker
☐ Self Employed
☐ Unemployed
☐ Unknown</td></tr>
</table>

Employer/ School name					
Phone(home)		**Phone (mobile)**			
Phone(work)		**Ext.**			
Home Address					
City		**Township**		**County**	
State		**Zip Code**		**Work Zip**	
Other Address				**Address Type** Previous ◯ Mailing ◯ Other ◯	

<table>
<tr><td># in Family ________
NAME
______
______
______
______
______
______</td><td>List name and relationship to the child of all family members in the household.</td><td>* # in Household ________
RELATIONSHIP
______
______
______
______
______</td><td>Marital Status</td><td>☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Separated
☐ Other</td></tr>
<tr><td>Disabled</td><td>☐ Yes ☐ No</td><td>Medical Insurance (for Child)</td><td>☐ Yes ☐ No</td><td>Specify:</td><td>☐ Aetna Global Benefits
☐ AHA Care
☐ Ambetter
☐ ARKids 1st
☐ ARKids A
☐ ARKids B
☐ blue advantage
☐ Blue Cross Blue Shield
☐ CareFirst</td></tr>
</table>

					Cigna Health Network for Louisiana Medicaid Medicare Private Health Coverage QualChoice TriCare UnitedHealthCare
*Current Housing	Homeless Own Rent Other	*Current Housing Date	mm-dd-yyyy / /	*Previous Housing	Homeless Own Rent Other
Has this family moved in the last 24 months?			Yes No		
Primary Caregiver Comment					
No Secondary Caregiver (skip application for secondary caregiver)					

Secondary Caregiver General Information					
First Name		M. Initial		Last Name	
Gender	Male Female	Birth Date	mm-dd-yyyy / /		
SSN					
Language			Other Language		

*Ethnicity	*Race		
Hispanic	American Indian or Alaska Native	Asian Indian	Black or African American
Yes, Cuban	Chinese	Filipino	Guamanian or Chamorro
Yes, Mexican, Mexican American, Chicano	Immigrant	Japanese	Korean
Yes, Other Spanish, Hispanic, Latino	Migrant	Multi-Racial	Native Hawaiian
	Other	Other Asian	Other, Pacific Islander
Yes, Puerto Rican	Samoan	Unknown	Vietnamese

	☐ White				
Education Level	☐ Bachelor or Advanced Degree ☐ College degree or training school certificate ☐ ESL ☐ GED ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ Grade 9 or less ☐ High School Graduate ☐ No High School ☐ Some College/Vocational/Associates Degree ☐ Some High School ☐ Unknown		**Employment Status**	☐ Farmer ☐ Full-time & training ☐ Employed full-time ☐ Homemaker ☐ Job training/school(part-time) ☐ Migrant Farm worker ☐ Part-time & training ☐ Employed part-time ☐ Retired or disabled ☐ Job training or in school ☐ Employed seasonal ☐ Seasonal Farm worker ☐ Self Employed ☐ Unemployed ☐ Unknown	
Employer/ School name					
Phone(home)		**Phone(mobile)**			
Phone(work)		**Ext.**			
Home Address	☐ Same as Primary Caregiver's				
City		**Township**		**County**	
State		**Zip Code**		**Work Zip**	

Disabled	☐ Yes ☐ No	**Medical Insurance**	☐ Yes ☐ No	**Specify**	☐ Aetna Global Benefits ☐ AHA Care ☐ Ambetter ☐ ARKids 1st ☐ ARKids A ☐ ARKids B ☐ blue advantage ☐ Blue Cross Blue Shield ☐ CareFirst ☐ Cigna ☐ Health Network for Louisiana ☐ Medicaid ☐ Medicare ☐ Private Health Coverage ☐ QualChoice ☐ TriCare ☐ UnitedHealthCare
Secondary Caregiver Comment					

Signature: ______________________ Date: ______________________	Signature: ______________________ Date: ______________________

Fields marked with (*) are required for PIR report

Arkansas Department of Human Services
Division of Child Care and Early Childhood Education

ARKANSAS BETTER CHANCE PROGRAM
WELL CHILD SCREENING (EPSDT) FORM

To Parent or Guardian:
In order to provide the best learning experience for your child, teacher must understand your child's health needs. State regulations require any child enrolled in the Arkansas Better Chance Pre-K program to have a well child check-up. In addition, the child must be current on all required immunizations. Please complete this page of the form, sign it and give it to your child's physician or licensed nurse practitioner. Once form is completed and signed on both sides, return the form to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

Address, City and Zip Code

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number

Type of Health Insurance	
D AR Kids A	D Private Insurance
D AR Kids B	D Other:

Part I – To be completed by parent or guardian before well child screening.

Check answers to the following questions. Explain any "yes" answers in the space provided.

	Yes	No	
1.	D	D	Do you have any concerns about your child's general health?
2.	D	D	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	D	D	Does your child have any allergies (like to food, medicine, dust)?
4.	D	D	Does your child take any medications (daily or occasionally)?
5.	D	D	Does your child have any problems with vision, hearing or speech?
6.	D	D	Has your child had any hospitalization, operation, major illness or injury?
7.	D	D	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	D	D	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	D	D	Has your child had a dental examination in the last 12 months?
10.	D	D	Would you like to discuss anything about your child's health with the health care provider?

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:
I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance program.

Signature of Parent/Guardian ______________________ Date ______________

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:
This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight	Height	BMI	Temp	Blood Pressure
lb. %ile	in. %ile	%		/

History Update
D Yes D No Any changes in patient health since last visit? Explain:____________________
D Yes D No Any family history of heart disease for anyone under 55 years of age?
D Yes D No Any family history of abnormal cholesterol?

Health
D Good appetite
D Drinks lowfat milk
D Encourage diet of fruit and vegetables
D Limits fast food
D Picky or variable eater
D Brushes teeth, sees dentist

Social and Behavioral
D Parents discipline appropriately
D Dresses self, helps at home
D TV and video games are limited
D Praised for good behavior
D Has friends and playmates

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L________ R		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

PHYSICAL EXAM

	Norm	Abnormal
General	D	D
Head	D	D
Neck	D	D
Eyes	D	D
Ears	D	D
Nose	D	D
Throat	D	D
Mouth	D	D
Teeth	D	D
Lungs	D	D
Heart	D	D
Femoral Pulses	D	D
Genitals	D	D
Extremities	D	D
Gait	D	D
Spine	D	D
Skin	D	D
Neuro	D	D

Immunizations
D Yes D No All immunizations are current.
D Yes D No Child has had all immunizations possible at this time.
Child needs: D DTaP D IPV D HepB D HiB D MMR D Varivax D PCV-7 at______years/______months

Referrals
D Follow up visit needed in __________ weeks / months
D Return check at_______years________months
D Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions
D Well child, normal growth and development
D ______________________________

______________________________, MD / DO / NP
Date______________________________

CLINIC INFORMATION (or stamp)

Name________________________
Address______________________
City_________________________
Zip Code______Phone____________

Verification of Zero Earned Income

I, ____________________, do hereby declare that I am:

_____ not employed, have zero earned income, and not receiving unemployment benefits at this time.

_____ disabled and have zero earned income.

Verification of Employment

Business Name: ______________________________

Hire Date: __________________ Phone Number: ________________________

I, __________________________, currently employ ____________________________________,
Owner — Employee's First & Last Name

Gross Earned Income: _______________

__________ weekly ___________ bi-weekly __________ monthly ___________ annually

Notarization

Printed Name: ____

Signature: ____ Date: ______________

- Signature - *document must be signed in front of the Notary and notarized.*
- *Photo Identification is required to be presented to notary.*

State of __________________________________

County of ________________________________

Signed and sworn before me, a Notary Public, this ________ day of __________, _______

____
Notary Public Signature

My commission expires _________________.

INCOME ELIGIBLITY WORKSHEET

CHILD NAME:____________________ DATE OF APPLICATION: __________ ELIGIBLE: __YES __NO

Note: Paycheck stubs must be in consecutive order within the last four pay periods from the date of enrollment. Make copies of income verification to be placed in the child's file.

Paid Weekly		Paid Bi-Weekly		Paid Twice Monthly		Paid Monthly	
Income #1		**Income #1**		**Income #1**		**Income #1**	
Date of Check	Gross Amount	Date of Check	Gross Amount	Date of Check	Gross Amount	Date of Check	Gross Amount
______	$ ______	______	$ ______	______	$ ______	______	$ ______
______	$ ______	______	$ ______	______	$ ______		
______	$ ______						
______	$ ______	Total	$______/2	Total	$______/2	Total	$______/1
Total	$______/4						
Weekly Average	$ ______ (4.334)	Bi-Weekly Average	$ ______ (2.167)	Twice Weekly Average	$ ______ (2.0)		
Monthly Total X	$ ______ 12	Monthly Total X	$ ______ 12	Monthly Total X	$ ______ 12	Monthly Total X	$ ______ 12
Annual Income	**$ ______**	**Annual Income**	**$ ______**	**Annual Income**	**$ ______**	**Annual Income**	**$ ______**
Income #2		**Income #2**		**Income #2**		**Income #2**	
Date of Check	Gross Amount	Date of Check	Gross Amount	Date of Check	Gross Amount	Date of Check	Gross Amount
______	$ ______	______	$ ______	______	$ ______	______	$ ______
______	$ ______	______	$ ______	______	$ ______		
______	$ ______						
______	$ ______	Total	$______/2	Total	$______/2	Total	$______/1
Total	$_____/4						
Weekly Average	$ ______ (4.334)	Bi-Weekly Average	$ ______ (2.167)	Twice Weekly Average	$ ______ (2.0)		
Monthly Total X	$ ______ 12	Monthly Total X	$ ______ 12	Monthly Total X	$ ______ 12	Monthly Total X	$ ______ 12
Annual Income	**$ ______**	**Annual Income**	**$ ______**	**Annual Income**	**$ ______**	**Annual Income**	**$ ______**
Federal Income Tax Forms / Gross Income: $____________		Food Stamp Eligibility Documentation within 30 days $____________		DHS Caseworker document verifying less than 200% FPL $ ____________		Total in Family: _____ Total Family Income: $____________	

__ Active Military Overseas __ Incarcerated Parent __ No earned Income
__ Custody of or living with other relative __ Foster Care

ENROLLMENT APPLICATION CHECKLIST

No application is complete until all requirements are check on the list below:

- ☐ ABC Child Application
- ☐ ABC Well Child Screening Form
- ☐ Birth Certificate or Hospital Record
- ☐ Immunization Record (with catch up schedule if necessary)
- ☐ USDA Food Program Eligibility Form
- ☐ Proof of Income: Total Family Income
    - ☐ 30 days current pay stubs
    - ☐ Income Tax Form
    - ☐ W2
    - ☐ Other ______________________________
- ☐ If unemployed:
    - ☐ Current school schedule
    - ☐ Notarized statement signed by the parent stating that there is no earned income.

With the signature(s) below, I agree that the above requirements are completed and that all information is accurate. I understand that the submission of false documentation to receive ABC services may result in exclusion from participation in any DHS program (including Medicaid) and referral for criminal prosecution.

Child's Name: ______________________________

Parent Signature: ______________________________ **Date:** ____________

Program Staff: ______________________________ **Date:** ____________