



Arkansas Better Chance Program

P.O. Box 1437, Slot S-160

Little Rock, Arkansas 72203

			C	hild App	licat	ion:		
Agency Quality C	hild Care		Y.	Арј	olican	t For	Current Yea	ar Next Year
Center	QCC FS	3		Address 2015 S. S Ft. Smith	Savanr		Phone 479-646-3479	
First Name			M. Initi	ial	La	st Name		
Application Date	/	/	Gender	•		Male Female	*Birth Date mm-dd-yyyy	/ /
			Dem	ographic 1	Inform	mation		
*Primary Languag	ge		Otl	her Langua	age			
Speak English at l	home?	Yes	Eng	glish Skills	,	Very We	ell Well Not At All	Not Well
*Ethnicity Hispanic Yes, Cuban Yes, Mexican, Mexican, Chicano Yes, Other Spatispanic, Latino Yes, Puerto Ric	nish,	Native Chin	ese nigrant ant er oan	ian or Alask	ka	Filipi Japa Mult Othe	ino American Guam nese Korea i-Racial Native	e Hawaiian , Pacific Islander
SSN			Oth	ner ID			US Citizen	Yes No
			Eli	gibility Inf	forma	ition		
*Parental Status								
Two Parent	Single F	Parent				г	П	
reen Parent			-	Disabled Pa	arent	F-	oster Parent	Active Male
Homeless Student Parent			Г	Migrant Par	outers of b .	1	Grand Parent	Dual Custody

Г	Previously in Foster Care				
Rel	lation to Primary Caregiver				
Rel	lation to Secondary Caregiver				
	Additiona	l Eligib	oilit	y Information	
			Dis	ability Status	
Γ.	Special Need		Г	No Suspected Certified	IEP
	эресіаі меец		Г	Certified IFSP	
П	Child Protective Services		Г	Non-English Speaking/LEP	
	Incarcerated Parent				
Г			_		
Moi	Non-parental custody/not living with ther/Father		1	Active Duty	
	Arrested/Convicted of Drug Offense		Г	Completed H3	
Γ	No HS Diploma		Γ	Completed H4	
Г	Waiver			Completed H5	
	Low Birth Weight		Г	Enrolled in HIPPY Year 1	
	Parent < 18 yrs. of age at birth		П	Enrolled in HIPPY Year 2	
	Substance Abuse/Addiction		Γ	Enrolled in HIPPY Year 3	
	History of Abuse/Neglect/Victim		П		
	Parents cannot read		Π		
	Title I				
	IDEA				
	Developmental Delay		Г		
Add	litional Points (Agency use only)				
	Prog	ıram Iı	nfor	mation	
*Pr	ogram Model (Agency use only)	*Prog	grai	n Options (Agency use only)	Hours Per Day
	Orl	her Inf	orn	ation	
-		ilei Till	JIII		-1110
Anna.	*Full-Year Needed			*Full-Day Needed	
	* Child is receiving a childcare subsidy (Vous	char ar	Con	tracted clot)	

*Father/father figure participates in regularly	y 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)	Professional and a second of the Professional Control of t
*Did child receive services before classes began i School Year?	n the current Yes No
	SDA Information
USDA Enrollment Date USDA Exp	Diration Date USDA/CACFP Income
	onal Needs & Services
Child Needs Full Time Care Part Time Care Enrolled but Waiting (for transition):	F Evening Covernight Weekend
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





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Little Rock, Arkansas 72203

		Family	Eligibility Appli	cation							
Enrolling Agency	Quality Child Care				FS S. Savannah mith, 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		3 12	*Other Language			*Food Stamp / SNAP Yes No					
American, Yes, O Latino	uban Iexican, Mexican	*Race American Alaska Native Chinese Immigran Migrant Other Samoan White		Filipino Japanese Multi-Racial Other Asian	Black or Afric Guamanian o Korean Native Hawai Other, Pacific Vietnamese	r Chamorro ian					
Education	Level	Bachelor or Adv College degree of school certificate ESL GED Grade 10 Grade 11 Grade 12		Employment Status	Farmer Full-time & Employed full-time & Farmer Full	ull-time /school(part-time) m worker training					

Other Address # in Family					\$200.000 \$100.000		
No High School Some College/ Vocational/Associates Degree Some High School Unemployed Unemployed Unemployed Unemployed Unknown U		Grade 9 or less			Retired or o	disabled	
Some College/ Vocational/Associates Degree Some High School Unknown Employer/ School name Phone(home) Phone(work) Home Address City State Township State Other Address Fin Family NAME List name and relationship to the child of all family members in the household. In the household. Marital Status Married Single Widowed Separated Other Address Maridosa Widowed Address Fin Household Issued Insurance (for Child) Disabled Fyes No Medical Insurance (for Child) Blue Cross Blue Shield		High School Gra	duate		Job training or in school		
Vocational/Associates Degree Some High School Unknown Employer/ School name Phone (mobile) Phone(work) Home Address City State Other Address # in Family NAME List name and relationship to the child of all family members in the household. # in the household. Township County		No High School	Employed s	easonal			
Vocational/Associates Degree Some High School Unknown Employer/ School name Phone(home) Phone(work) Ext. Home Address City State Cher Address Fin Family NAME List name and relationship to the child of all family members in the household. Township In Family NAME Disabled Press No Medical Insurance (for Child) Medical County Sepecify: Self Employed Unemployed U		Some College/			Seasonal Fa	ırm worker	
Employer/ School name Phone(home) Phone(work) Fixt City State Other Address # in Family NAME List name and relationship to the child of all family members in the household. Disabled Disabled Fyes No Medical Insurance (for Child) Fine Ambetter Arkids A Arkids B blue advantage File Conney Unemployed Unknown Valena Marital Status Married Fine Single Fine Single Fine Separated Fine Separate		1	es Degree		Salf Employ	nad.	
Employer/ School name Phone (mobile) Ext. County State County Fin Family NAME List name and relationship to the child of all family members in the household. It is not all family members in the household. Marital Status Married Marital Status Married Marital Status Married Fin Household Married Married Married Fin Household Married Marri		Some High Scho	ol		ا ا		
Employer/ School name Phone (Imobile) Phone (Imobile) Phone (Imobile) Phone (Imobile) Ext. Fix. County County		Unknown			-	u	
Phone(work) Phone(work) Fxt. Home Address	Employer/ School name				Onknown		
Phone(work) Ext.	Dhono/homo)		Phone				
Home Address City State Township Zip Code Work Zip Address Type Previous Mailing Other RELATIONSHIP List name and relationship to the child of all family members in the household. Township Warital Status Married Marriad Status Married Married Married Single Divorced Separated Other Other Aetna Global Benefits AHA Care Ambetter ARKids 1st ARKids 1st ARKids 1st ARKids 8 blue advantage Blue Cross Blue Shield	rnone(nome)		(mobile)			Photos No. All and a construction of a construct to Annal P. of Reduction and A. A. A. Ph. A.	
City Township County State Zip Code Work Zip Other Address Other Address # # in Household Mailing Other Single Previous Mailing Other Single Previous Mailing Other Married # # in Household Married Single Single Single Single Divorced Work Zip Married Namiling Other Single Divorced Widowed Separated Other Other Aetna Global Benefits AHA Care Ambetter ARKids 1st ARKids 1st ARKids 1st ARKids 8 blue advantage Blue Cross Blue Shield Blue Cross Blue Shield County Address Type Married Single Divorced Warried Single Divorced Arkids 1st ARKids 8 Blue Cross Blue Shield County Address Type Address Type Previous Mailing Other Amaried Single Divorced Amaried Arkids 1st ARKids A ARKids B Blue Cross Blue Shield Blue Cross Blue Shield County Address Type Previous Mailing Other Address Type Arkids Status ARKids A ARKids B Blue Cross Blue Shield Arkids B Arki	 		Ext.				
State Other Address # in Family NAME List name and relationship to the child of all family members in the household. Disabled Disabled Tyes No No Medical Insurance (for Child) Yes No No Specify: ARKids A	Home Address		Frontier = miner (v.A.) (1800 / m. 1885 / 118 (m. 1885 / 118			to the second	
Other Address # in Family	City				, ,		
Other Address # in Family	State		Zip Code				
# in Family	Other Address						
NAME List name and relationship to the child of all family members in the household. Disabled Per No Medical Insurance (for Child) Yes No Specify: Marital Status Married Single Divorced Widowed Separated Other AAtna Global Benefits AHA Care ARKids 1st ARKids 1st ARKids A ARKids B blue advantage Blue Cross Blue Cross Blue Cross Blue Cross Blue Cross				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Previous M	ailing Other	
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Disabled Disabl		in the household.			-	「 Separated	
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Disabled Yes No No Medical Insurance (for Child) Yes No Specify: ARKids 1st ARKids A ARKids B blue advantage Blue Cross Blue Shield						AHA Care	
Disabled Yes No Medical Insurance (for Child) Yes No Specify: ARKids A ARKids B blue advantage Blue Cross Blue Shield						Ambetter	
Disabled Yes No Insurance (for Child) Yes No Specify: ARKids A ARKids B blue advantage Blue Cross Blue Shield						ARKids 1st	
(for Child) ARKids B blue advantage Blue Cross Blue Shield	Disabled	r Voc r No	1	L Act No	Specify:	ARKids A	
blue advantage Blue Cross Blue Shield		I ES INO	1) ICS NO		ARKids B	
advantage Blue Cross Blue Shield							
Blue Shield							
Blue Shield						Blue Cross	
CareFirst						{	
					Proceedings of the Control of the Co	CareFirst	

					Cigna Health Network for Louisiana Medicaid Medicare Private Health Coverage QualChoice TriCare
*Current Housing	Homeless Own Rent Other	*Current Housing Date	mm-dd-yyyy / /	*Previous Housing	UnitedHealthCare Homeless Own Rent Other
Has this family moved in the	last 24 months?	- Victoria (1 - Mariani 17 Albani) (1 - Alba	Yes No	- Participation (Commission - Commission) - Participation (Commission Commission Commission (Commission Commi	
Primary Caregiver Comment No Secondary Caregiver (skip	application for second	dary caregiver)			
	Secondary	Caregiver General	Information		
First Name	The colonial and constitution of the state o	M. Initial		Last Name	
Gender	Male Female	Birth Date	mm-dd-yyyy	/	/
SSN					
Language			Other Language		
*Ethnicity	*Race				
Hispanic	American Indian	or Alacka Native	Asian Indiar	T Black or	African American
Yes, Cuban	good			T	
	Chinese		¹ Filipino	-	ian or Chamorro
Yes, Mexican, Mexican American, Chicano	Immigrant		¹ Japanese	Korean	
	Migrant		Multi-Racia	Native H	lawaiian
Yes, Other Spanish, Hispanic, Latino	Other		Other Asian	Other, P	acific Islander
	Samoan		Unknown	Vietnam	
Yes, Puerto Rican	Juinoun		SHRIOWIL	VICTIBILI	

ABC Form # 003 (Eff. Date 07/01/15)

	┌ White		turing and have also designed to the second sec		A dament
Education Level	College degree or tr certificate ESL GED Grade 10 Grade 11 Grade 12 Grade 9 or less High School Graduat No High School	ESL GED Grade 10 Grade 11 Grade 12 Grade 9 or less High School Graduate No High School Some College/Vocational/Associates egree Some High School		Employ Homen Job trai Migran Part-tir Employ Retired Job trai Employ	ne & training yed full-time naker ining/school(part-time) t Farm worker me & training yed part-time or disabled ining or in school yed seasonal al Farm worker ployed loyed
Employer/ School name	nı	ono/mobile)	/ January 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		oostoon oo
Phone(home) Phone(work)	Pn Ex	one(mobile)			anning and a second of the second second and the second second second second second second second second second
Home Address	Same as Primary Car	ray ng straying ngan gawangangang tay dandan ing singag tradistransan anta Missansan and Massansan a	1		
City	То	wnship		County	
State	Ziţ	o Code		Work Zip	

ABC Form # 003 (Eff. Date 07/01/15)

Disabled	Yes No	Medical Insurance	Yes The 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:	2:		

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

ame of Pre-k	Program Where Enrolled	阿克勒斯是第四次主义 中心。	Pre-K Program Phone Number
ype of Health	Insurance		
AR Kids A AR Kids B	D Private Insurance D Other:		
art I – To be	completed by parent or gu	ardian before well child scree	ning,
heck answer	rs to the following question	ns. Explain any "yes" answe	ers in the space provided.
	D Has your child by Does your child by Does your child by Does your child by Does your child by D Has your child by D In the past 12 more D Has your child by D Would you like to be seen any question, pleas	have any allergies (like to food, take any medications (daily or o have any problems with vision, lad any hospitalization, operation onths, has your child experience onths, has your child experience ad a dental examination in the lad discuss anything about your cl	disease (such as asthma or diabetes)? medicine, dust)? ccasionally)? hearing or speech? n, major illness or injury? ed any difficulty with wheezing or night coughing? ed excessive weight loss or weight gain?
uestion #	Explanation	然的是,我是一个是一个人的。	中华以及李建设在《美国东西
		,	
		A A A A A A A A A A A A A A A A A A A	

Child's Name	(Last, First, I	Middle)	Child's Date	of Birth	Sex	Parent/	Guardian Name	REPORT !
creening for all e Screening and Di	lled in the Arka enrolled childre agnostic Treat	ansas Better Chance en. The Division of tment (EPSDT) whic Is A or B using the p	Child Care an h is age-appr	d Early Chi opriate. Fo	Idhood Edi	ucation recomn	nends an Early Per	riodic
	Patient Type New Established	AR k 1-4 years 99382 EP U1 99382 EP U2	(IDS A 5-11 yea 99383 EP 99383 EP	U1	AR -4 years 99382 99382	5-11 yea 99383 99383		
art II – To be c	ompleted by	Health Care Provid	ler. Comple	te all sectio	ns and sig	gn at the botto	m.	
We	ight	He	ight	al regar	ВМІ	Temp	Blood Pressu	ire
Ib	o. %	ile in	%	ile	%		1	
Yes D No ealth		story of heart disease story of abnormal cho	lesterol?	•			PHYSICAL	
ealth Good appetite Drinks lowfat m Encourage diet		D Brus	y or variable shes teeth, se			4	PHYSICAL Norm General D Head D	Abnorma D D
Limits fast food ocial and Behar Parents discipling Dresses self, he TV and video go creening and La	vioral ne appropriate elps at home ames are limit	D Has ed	sed for good friends and p				Eyes D Ears D Nose D Throat D Mouth D Teeth D Lungs D Heart D	D D D D D D
Test	Res	ult	Date	Commen	ts if abnor	rmal	Femoral Pulses D	D
Vision Test type:	L R						Genitals D Extremities	D
Hearing					,		D	D
Test type: TB							Gait D Spine D	D D
Risk: Yes / No							Skin D Neuro D	D D
Hemoglobin					-			0 12 8
Risk: Yes / No Cholesterol Risk: Yes / No		mg/dl	-		1			
mmunizations OYes DNo OYes DNo Child needs: DD	Child has had TaP D IPV	ions are current. all immunizations p D HepB D HiB D	MMR DVa		CV-7 at_	years/_	months	
Follow up visit n Return check at Needs to see de	needed in tye entist. Referra	week arsmon al to be made by phy	s / months ths sician or nurs	e practition	er.		RMATION (or sta	
npressions						Address		
Well child, norm	nal growth and	development				City		
THE AVERSON BUILDING A	9					Zip Code	Phone	

Date_

D_____

___, MD / DO / NP

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:								
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.

\$ Total \$ Total \$ Total \$ Total \$ Average (4.334) \$ Average \$		
Date of Check Gross Amount Date of Check Gross Amount Date of Check Gross Amount Date of Check Date of Check Date of Amount Check Date of Check	Gross Amount \$	
Check Amount Total Sample To	Amount \$	
S	\$	
\$ Total \$ Total \$ Total \$ Total \$ Average (4.334) \$ Average \$		
S	\$/1	
\$ Total \$/2 Total \$/2 Total \$/2 Total \$/2 Total \$/2 Total \$/2 \$	\$/1	
Total \$/4 Weekly \$ Average (2.167) Twice \$ (2.0) Average (4.334)	\$/1	
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Total \$/4		
Bi-Weekly \$ Twice \$ Weekly \$ Weekly (2.0)		
Average (4.334) Average		
Monthly \$ Monthly \$ Monthly \$ Monthly	\$	
Total Total Total Total	Y	
X	12	
Annual Annual Annual Annual		
	\$	
Federal Income Tax Food Stamp Eligibility DHS Caseworker Total in Famil	·	
Forms / Gross Income: Documentation within 30 document verifying less Total Family		
days than 200% FPL		
\$ \$ \$ \$ \$		
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:

The property of the state of th	
ABC Child Application	
ABC Well Child Screening Form	Ì
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	
Other	ANALY STATE OF THE
☐ If unemployed:	
Current school schedule	
Notarized statement signed by the parent stating that the	ere is no earned income.
With the signature(s) below, I agree that the above requirements ar information is accurate. I understand that the submission of false d ABC services may result in exclusion from participation in any DHS p Medicaid) and referral for criminal prosecution.	locumentation to receive
Child's Name:	***************************************
Parent Signature:	Date:
Program Staff:	Date: