



Partnership for Children
(919)735-3371



WAGES Head Start
(919) 734-1178

Wayne County Preschool Application

Application Date: _____ School Yr Applying for: _____ Enrollment Date: _____

1st year
 2nd year

CHILD and FAMILY INFORMATION

Child's Legal Name: Last		First	Middle
Child's Social Security Number:		Date of Birth:	
Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Name:		
Name of Person(s) Child Lives With:		Relationship to child:	
Street Address:		Mailing Address: (if different)	
City:	State:	Zip Code:	County:
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	
Is child a United States resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is child a North Carolina resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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 HealthChoice <input type="checkbox"/> TriCare <input type="checkbox"/> Private <input type="checkbox"/> None		
If applicable, please list insurance number:		
Which of the following health concerns or problems relate to this child? <input type="checkbox"/> Behavior/Emotional Problems <input type="checkbox"/> Medically Fragile <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Allergies <input type="checkbox"/> Rashes <input type="checkbox"/> Fears <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Chronic Health Problems (such as Asthma, Diabetes, Arthritis) <input type="checkbox"/> No significant health concerns		
List any medications child currently takes:		

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:
6	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()
	<input type="checkbox"/> Release	Relationship:	City:	State: Zip:
7	<input type="checkbox"/> Contact	Name:	Address:	Phone: ()
	<input type="checkbox"/> Release	Relationship:	City:	State: Zip:
8	<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, regardless of parent/guardian preference expressed to provider.



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Parent/Guardian Signature: _____ Date: _____

CHILD & FAMILY INFORMATION

Child's Race: Black White Biracial/Multiracial American Indian/Alaska Native Pacific Islander Asian
 Hispanic/Latino Other (please indicate: _____)

Parent's Race: Black White Biracial/Multiracial American Indian/Alaska Native Pacific Islander Asian
 Hispanic/Latino Other (please indicate: _____)

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 Other

Total Family Size? _____ **Total Household Size (how many people live on the income listed on this application)?** _____

Mother Father Number of Children _____ Other Adults (age 18+) How many? _____

Does your family receive assistance from any of the following?
 AFDC/TANF Food Stamps Free/Reduced price School Meals

ADULT DEMOGRAPHIC INFORMATION

First and Last Name Enter Primary Adult First	Date of Birth	Social Security #	Sex M F	Marital Status	(D1) Educ 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 BA = Bachelors G11= Grade 11 DRP = Dropped out MA = Masters 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?
 < 90 days 3-12 months 13-18 months 19-24 months more than 2 years

If employed, how long has father (or secondary caregiver) been at current job?
 < 90 days 3-12 months 13-18 months 19-24 months more than 2 years

CHILD DEMOGRAPHIC INFORMATION

First and last name of children in home	Date of Birth	Social Security #	Sex M F	(D1) Related to	(D2) How Related	(D3) Notes e.g., program participation status, other programs, etc.
C01 -----program applicant-----	-----	-----	-----			
C02			M F			
C03			M F			
C04			M F			
C05			M F			
C06			M F			
C07			M F			



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C08		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			

ADDITIONAL INFORMATION

Indicate which of the following agencies this child has previously received or currently receives services from:

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Child Service Coordination |
| <input type="checkbox"/> Public Schools (List county, state _____) | <input type="checkbox"/> Children's Developmental Services Agency (formerly DEC) |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Early Childhood Intervention |
| <input type="checkbox"/> Other? _____ | |

SPECIAL NEEDS INFORMATION

Does this child have a disability or special need? Yes No Suspected

If Yes, what is diagnosis: _____
 Does child already have an IEP or IFSP? Yes No Comments: _____
 Is child receiving services related to disability? Yes No Date of Plan: _____

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

If Yes, who has child been referred to? _____

Optional: Any specific family need or crisis? Yes No (If yes, please explain:)

PLACEMENT LOCATION INFORMATION

What is your site preference? (please number first four choices from most to least favorite)

3 yr old sites: (Please note that transportation and extended day services are not available nor guaranteed at all sites)

___ Carver ___ Chestnut ___ Pikeville ___ Royall Avenue ___ Royall West

4 yr old sites: (Please note that transportation and extended day services are not available nor guaranteed at all sites)

___ Brogden Primary School	___ Bright Beginnings Childcare/Preschool (3)	___ Carver Elementary
___ Eastern Wayne Elementary School	___ Fremont Elementary School	___ Happy Days Childcare/Preschool (2)
___ Kids and Company	___ North Drive Elementary School	___ Northeast Elementary School
___ Meadow Lane Elementary	___ Mt Olive Kiddie Kollege	___ Rhyme University
___ Rosewood Elementary School	___ SJAFB Child Development Center (2)	___ School Street Elementary School (2)
___ Spring Creek Elementary School	___ Small World Childcare/Preschool (6)	___ Tommy's Road Elementary School
___ WAGES Carver (2)	___ WAGES Chestnut	___ WAGES Pikeville
___ WAGES Royall Ave (4)	___ WAGES Royall West	___ Wee Are the World Childcare (3)
___ Wonderland	___ Other	

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? _____

TRANSPORTATION INFORMATION

Will transportation be needed? Yes No

If Yes, list Pick-up Location: _____

list Drop-off Location: _____

If No, how would child get to school? Walk-in Other Parent Parent's Initials: _____

RECRUITMENT INFORMATION

How did you learn about program? Flyer, Brochure, Poster Staff Person Word of mouth
 Radio/TV/Newspaper Family Friend Other: _____

EXTENDED DAY CHILD CARE INFORMATION



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Does this child currently receive subsidy assistance for childcare services? Yes No
 If No, is child/family currently on subsidy waiting list? Yes No

Will extended day childcare services be required for this child? 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: _____

HEAD START FAMILY INCOME CALCULATION

Weekly x 52 = Annual Income Bi-Weekly x 26 = Annual Income Twice Monthly x 24 = Annual Income Monthly x 12 = Annual Income

Family Member	Amount	Per	x	Annual Income	Income Source
	\$			\$	
	\$			\$	
	\$			\$	
	\$			\$	
Total Family Gross Annual Income				\$	
Other Adult Household Members	Amount	Per	x	Annual Income	Income Source
	\$			\$	
	\$			\$	
Total CACFP Gross Annual Income				\$	

MORE at FOUR FAMILY INCOME CALCULATION

Weekly = Gross Pay x 4.333 x 12mo Bi-Weekly = Gross Pay x 2.167x 12mo Twice Monthly = Gross Pay x 24 Monthly = Gross Pay x 12 mo

Family Member	Amount	Per	x	Annual Income	Income Source
	\$			\$	
	\$			\$	
	\$			\$	
	\$			\$	
Total Family Gross Annual Income				\$	

Family Income Verified by Reviewing Following:

___ Pay Stubs ___ Income Tax Form(s) ___ W-2 Form(s) ___ Child Support ___ Statement from Employer
 ___ Statement from DSS ___ Other

Based upon the above income verification, child is ELIGIBLE INELIGIBLE for Head Start.

Verification Completed by: _____

MALE INVOLVEMENT-Applicable to Head Start Children Only

Can WAGES send information regarding center activity to any significant male role model(s) (father, uncle, grandfather, cousin, family friend, etc..) in your child's life? Yes _____ No _____ Initials _____

If Yes, please complete the following:

Name: _____

Address: _____



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City: _____ State: _____ Zip: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

PARENT AND/OR 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 federal and/or 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 Head Start and/or More at Four programs. 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. I give up my rights to confidentiality for these purposes only.

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 agree to allow any and all documents pertaining to my child's enrollment of the program to be released to the school system of the child's kindergarten enrollment. I understand that this consent for release of information is voluntary. _____ (parent initials)

I certify that I am the parent/guardian of the child for whom this application is being made.

Parent (Primary Caregiver) Signature (required)

Date

Parent (Secondary Caregiver) Signature (if available)

Date

Interviewer's Signature (required)

Date

Verifications

<input type="checkbox"/> Child's Birth Certificate	<input type="checkbox"/> Military ID
<input type="checkbox"/> Child's Social Security Card	<input type="checkbox"/> Proof of Income (current pay stub, LES, child support,W-2 Head Start Only)
<input type="checkbox"/> Child's Medicaid card or Private Insurance card	<input type="checkbox"/> AFDC/TANF (Letter stating award of money received), if applicable



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<input type="checkbox"/> Child's Physical (within last 12 months)	<input type="checkbox"/> Food Stamp Card, if applicable
<input type="checkbox"/> Child's Immunization Record	<input type="checkbox"/> Verification of child's special needs if applicable (IEP)
	<input type="checkbox"/> Other