Crowley's Ridge Cooperative ABC Program
Marked Tree ABC Program

The Arkansas Better Chance (ABC) program is a state funded program that provides free preschool services to children of low income families. Some spaces are also available for children with special needs who do not qualify under the income guidelines. Income guidelines are on the back of this page.

All the following documents must be submitted to determine eligibility in the program:
Required Documents

____ Resident of school district served by ABC Site School District ____________________
____ Birth Certificate Child must be 3 or 4 by August 1, 2019
____ Proof of Income One complete month of check stubs, Current year W2 or Tax return
____ Shot Record Shots must be up-to-date and remain so to continue in program
____ Copy of Social Security Card
____ Completed, Signed, and Dated Application
____Physical

Parents are responsible for transportation to and from school.

Applications will not be processed until ALL the above information is received and verified.

The child's physical is required *after* eligibility is determined.

For more information contact
Leann Lester, ABC Facilitator
Phone: 870-588-6843 Email: llester@crmail.k12.ar.us

Leave this application packet stapled together and return to the elementary office with all required documents. ***Only applications will all documents will be processed.***
Parents will be notified when application has been processed.

Crowley's Ridge Cooperative ABC Program

Marked Tree School District – Marked Tree Elementary

The Arkansas Better Chance (ABC) program is a state funded program that provides free preschool services to children of low-income families who are 3 years old by August 1st and whose parent is a resident of the school district. Income guidelines are listed on the next page. Some preschool spaces are also available for children with documented special needs who do not qualify under the income guidelines.

Child's Name ______________________________________ Date of Birth__________

Parent's Name __________________________________ Phone Number ___________

_____Yes No _____ Is the parent of this child a resident of Marked Tree School District?
_____Yes No _____ Will this child be 3 years old by August 1 of the school year applying for?
_____Yes No _____ Does the family of this child meet the income guidelines on the next page?
_____Yes No _____ Is English the primary language spoken in the home?

_____Yes No _____ Does the child live with someone else without a parent in the home?
_____Yes No _____ Does this child receive any special education services?
_____Yes No _____ Was either parent under 18 at the time of this child's birth?
_____Yes No _____ Does this child have a documented developmental or speech delay?
_____Yes No _____ Is there documented substance abuse/addiction in child's immediate family?
_____Yes No _____ Is there documented abuse or neglect in the immediate family or to this child?
_____Yes No _____ Is this child a foster child?
_____Yes No _____ Has a parent of this child been incarcerated during lifetime of this child?
_____Yes No _____ Has an immediate family member of this child been arrested for a drug offense?
_____Yes No _____ Did this child weigh 5 lbs. 8 oz. or less at birth?
_____Yes No _____ Will this child also be enrolled in a HIPPY or PAT program?

Please make sure you have filled in the application completely. Do not leave anything blank! Children with incomplete or missing information will *not* be considered for placement in program.

INFORMATION FROM THIS FORM WILL BE VERIFIED BEFORE THE CHILD IS PLACED IN PROGRAM

I declare under the penalty of perjury and the rules and regulation of the Arkansas Better Chance program that the information supplied is true and correct at the time of application. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements my results in exclusion from DHS program and criminal prosecution.

____ Date______________________
Signature of Primary Caregiver

For more information contact Leann Lester 870-588-6843 llester@crmail.k12.ar.us

State Preschool Program Income Guidelines

2018-19 ABC Program Income Guidelines

Family Size	Maximum Income for the Family 200% of FPL
1	$24,280
2	$32,920
3	$41,560
4	$50,200
5	$58,840
6	$67,480
7	$76,120
8	$84,760
For each additional Person add	$8,640 per person

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

CHILD______________________________ **SCHOOL**_______________

PRIMARY CAREGIVER INFORMATION (PARENT OR GUARDIAN WITH MOST CONTACT)

Parent/Guardian Name (First/Middle/Last):_____________________________________

Date of Birth:________________ Home Phone:_____________________________

Current Address_______________________ City:____________ St.____ Zip:_________

Email Address:____________________________

Employer:________________________ Work Phone:___________________________

Employment Status: Full Time_____ Part Time________ Number of Hours Per Week:________

Employment City _______________ State____________ Employment Zip: ____________

Education Level: High School Diploma_____________ College Diploma_________________

Only completed Up to Grade__________ Some College________________

If Attending School, where: _________________ Number of Semester Hours: ____________

Annual Income from Work Sources or Unemployment______________________________

Language Spoken in the Home___________Race__________ Disabled: Yes______ No______

Food Stamps/SNAP YES________ NO________ Marital Status_______________

Medical Insurance: Yes_____ No_____ Name of Medical Insurance: ___________________

Current Housing: Rent_____ Own_____ Homeless_____ Other________________________

Start Date For This Housing Situation: _______________

Has family moved in 24 months (yes or no)? __________

SECONDARY CAREGIVER INFORMATION (MARRIED, TWO-PARENT HOUSEHOLDS ONLY)

Parent/Guardian Name (First/Middle/Last):_____________________________________

Date of Birth:________________ Home Phone:_____________________________

Current Address_______________________ City:____________ St.____ Zip:_________

Email Address:____________________________

Employer:________________________ Work Phone:___________________________

Employment Status: Full Time_____ Part Time________ Number of Hours Per Week:________

Employment City _______________ State____________ Employment Zip: ____________

Education Level: High School Diploma_____________ College Diploma_________________

Only completed Up to Grade__________ Some College________________

If Attending School, where: _________________ Number of Semester Hours: ____________

Annual Income from Work Sources or Unemployment______________________________

Language Spoken in the Home___________Race__________ Disabled: Yes______ No______

Food Stamps/SNAP YES________ NO________ Marital Status_______________

Medical Insurance: Yes_____ No_____ Name of Medical Insurance: ___________________

Current Housing: Rent_____ Own_____ Homeless_____ Other________________________

Start Date For This Housing Situation: _______________

Has family moved in 24 months (yes or no)? __________

HOUSEHOLD INFORMATION

The number of immediate family members living in house: Parent, guardian, siblings________
Number in Household (The total number of people living in the house):_______

List the name, age and relationship to the child applying of all family members in the household:

Name	Relationship To Child Applicant	Age

CHILD INFORMATION

Name(First/Middle/Last)____

Date of Birth______________ Social Security Number_________________________

Gender ______ Ethnicity ___________

Has this child attended a state-funded pre-K (ABC) program before? Yes_____ No_____

If yes, where? ______________________________________

Will this child be concurrently enrolled in an ABC center and HIPPY or PAT program?

Yes___ No___ If yes, which HIPPY or PAT? ____________________________

List any allergies:____

Does the child have any special dietary needs?___________________________

Does this child receive any special education services?

Yes_________ No_______________

If Yes, what service is received?________________________________

Primary Language _______________

Secondary Language (If primary is not English)___________

Is English spoken in the home? Yes____ No____

Is child U.S. Citizen? Yes ____ No____

Parental Status:

Single Parent____ Two Parent____ Guardianship____ Foster____ No Parent in Home____

EMERGENCY CONTACT AND CONSENT INFORMATION

All information must be filled out and nothing left blank:

Name of emergency contact if parent/guardian cannot be reached ______________________________

Address____Phone__________________

City___________________________State_______________Zip___________Relationship____________

Physician

Name___________________________Phone____

Address_________________________________City____________________State______Zip__________

Consent For Emergency Medical Care

I_________________________________ __________________of______________________________

Parent/Guardian's Name **Relationship** **Child's Name**

Do hereby request and give consent to the Director/Caregiver of the child Care Facility, or their duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessarily expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s) cannot be reached. Consent is also given for the Director/Caregiver or their duly appointed representative to transport said child for emergency medical treatment, if parent(s) cannot be reached. I additionally give consent for my child to attend the above named field trip.

PARENT/GUARDIAN
SIGNATURE____**DATE**______________

THE CROWLEY'S RIDGE EDUCATION COOPERATIVE ABC PROGRAM DOES NOT TRANSPORT CHILDREN.

SIGNATURE

I declare under the penalty of perjury and the rules and regulations of the Arkansas Better Chance program that the information supplied is true and correct at the time of application. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements may result in exclusion from DHS programs and criminal prosecution.

Signature of Primary Caregiver ____**DATE**___________

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 ____________

Crowley's Ridge Cooperative ABC Program
Marked Tree School District - Marked Tree Elementary

Parent Contact Page

Child Name:______________________________________
Age of Child by Aug. 1 2019:__________________________

Parent
Name:____
Address:____
Phone:____
Email
Address:____

Preferred method of contact:
Please select at least one way, all maybe selected

_______phone call

_______text message

________email

______________________________ ________________________
Signature Date

Marked Tree School District
Marked Tree ABC Pre-K
Eschool Form

Child Full Name:______________________________

Race:________ Sex:________ Language:____________

Birth Certificate Number:______________________________

Social Security Number:______________________________

Physical Address:______________________________

Primary Caregiver Name:______________________________

Primary Caregiver Phone Number:______________________________

Secondary Caregiver Name:______________________________

Secondary Caregiver Phone Number:______________________________

Emergency Contact:

Name:______________________________

Number:______________________________

Relation to Child:______________________________