Partnership for Children
(919)735-3371

WAGES Head Start/Early Head Start
(919) 734-1178

Wayne County Preschool Application

☐ 1st year
☐ 2nd year

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

CHILD and FAMILY INFORMATION

Child's Legal Name: Last		**First**	**Middle**
Child's Gender: ☐M ☐F	**Date of Birth:**	**Preferred Name:**	
Name of Person(s) Child Lives With:		**Relationship to child:**	
Street Address:			
Mailing Address: (if different)			
City:	**State:**	**Zip Code:**	**County:**
Is child a US Citizen? ☐ yes ☐ no **Is child a NC Resident?** ☐ yes ☐ no			
Primary Phone: ☐ Home ☐ Message ☐ Cell ☐ Beeper/Pager ( ) -		**Alternate Phone:** ☐ Home ☐ Message ☐ Cell ☐ Beeper/Pager ( ) -	
May we contact you by email? ☐ Yes ☐ No **Email address:** _____		**May we contact you by text messaging?** ☐ Yes ☐ No **Cell phone:** _____ **Cell provider:** _____	

MEDICAL INFORMATION

Child's Doctor:	**Office Phone:**	**Address:**
Child's Dentist:	**Office Phone:**	**Address:**
Preferred Hospital:		
Please indicate which insurance this child currently receives? ☐ Medicaid ☐ NC HealthChoice ☐ TriCare ☐ Private ☐ None		
If applicable, please list insurance number:		**Date Medicaid or NC HealthChoice issued?**

Which of the following health concerns or problems relate to this child?

☐ No significant health concerns
☐ Behavior/Emotional Problems
☐ Seizures/Convulsions
☐ Developmental Delays
☐ Medically Fragile
☐ Hyperactivity
☐ Allergies
☐ Rashes
☐ Fears
☐ Chronic Health Problems (such as Asthma, Diabetes, Arthritis, Obesity)
☐ Other – please explain: _____

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	☐ *Contact* ☐ *Release*	**Name:** **Relationship:**	**Address:** **City:**	**Phone: ( )** **State:** **Zip:**
2	☐ *Contact* ☐ *Release*	**Name:** **Relationship:**	**Address:** **City:**	**Phone: ( )** **State:** **Zip:**
3	☐ *Contact* ☐ *Release*	**Name:** **Relationship:**	**Address:** **City:**	**Phone: ( )** **State:** **Zip:**
4	☐ *Contact* ☐ *Release*	**Name:** **Relationship:**	**Address:** **City:**	**Phone: ( )** **State:** **Zip:**
5	☐ *Contact* ☐ *Release*	**Name:** **Relationship:**	**Address:** **City:**	**Phone: ( )** **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 (usually Wayne Memorial Hospital), regardless of parent/guardian preference expressed to provider.

Parent/Guardian Signature: _____ **Date:** _____

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CHILD & FAMILY INFORMATION

Child's Race: ☐ Black /African American ☐ White ☐ Biracial/Multiracial ☐ American Indian/Alaska Native ☐ Pacific Islander/Native Hawaiian ☐ Asian ☐ Other (please indicate country of origin:)

Parent's Race: ☐ Black/African American ☐ White ☐ Biracial/Multiracial ☐ American Indian/Alaska Native ☐ Pacific Islander/Native Hawaiian ☐ Asian ☐ Other (please indicate country of origin:)

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?**

Housing Status ☐ Own home ☐ Rent home/apartment/mobile home ☐ Living with friends/relatives temporarily ☐ Living in shelter ☐ Living in hotel/motel ☐ Other (explain)_____

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**	**Sex**	**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** **AA** = Associates
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** _____

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
If unemployed, are you currently looking for employment? ☐ **yes** ☐ **no**
Are you currently pursuing post-secondary education? ☐ **yes** ☐ **no**

CHILD DEMOGRAPHIC INFORMATION

First and last name of children in home	**Date of Birth**	**Sex**	**(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			

(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

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ADDITIONAL INFORMATION

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

☐ None
☐ Public Schools (List county, state_____)
☐ Child Service Coordination
☐ Children's Developmental Services Agency (formerly DEC)
☐ Mental Health
☐ Early Childhood Intervention
☐ Other? _____

SPECIAL NEEDS INFORMATION

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

Comments: _____

If Yes, what is diagnosis: _____

Date of Plan: _____

Does child already have an IEP or IFSP? ☐ Yes ☐ No

Is child receiving services related to disability? ☐ Yes ☐ No

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, explain:)

SITE PREFERENCE INFORMATION

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

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

***WAGES* sites:**

____ Belfast ____ Carver ____ Chestnut ____ Herman ____ Royall Avenue ____ Royall West

***North Carolina Pre-K* sites:**

_____ Brogden Primary School
_____ Eastern Wayne Elementary
_____ Carver Elementary (Mt. Olive)
_____ Meadow Lane Elementary
_____ Spring Creek Elementary
_____ WAGES Carver (1)
_____ Bright Beginnings Childcare/Preschool (2)
_____ Fremont Stars Elementary
_____ North Drive Elementary
_____ School Street Elementary (NCPre-K)
_____ Small World Childcare/Preschool (5)
_____ WAGES Royall Avenue (3)
_____ Bright Beginnings II
_____ Happy Days Childcare/Preschool (2)
_____ Northeast Elementary
_____ Rosewood Elementary
_____ Tommy's Road Elementary
_____ Wee are the World (3) (Dudley)

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

(Transportation for North Carolina Pre-K students is currently only provided at WAGES Head Start sites and Wee Are the World)

Will transportation services be needed? ☐ Yes ☐ No

If Yes, list Pick-up Location: _____

list Drop-off Location: _____

WAGES offers limited transportation services. If bus transportation is not available, would you be able to get your child to and from school on a daily basis? ☐ Yes ☐ No Parent Initials: _____

EXTENDED DAY CHILD CARE INFORMATION

Will extended day childcare services be required for this child? (WCPS sites does not provide extended day) ☐ Yes ☐ No

If Yes, check all that apply: ☐ Before School Care ☐ After School Care ☐ Holiday Care ☐ Summer Care

Does this child currently receive subsidy assistance for childcare services? ☐ Yes ☐ No

If No, is child/family currently on subsidy waiting list? ☐ Yes ☐ No

Does family have alternative arrangements if extended day childcare services cannot be provided? ☐ Yes ☐ No

If Yes, with whom:

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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				$	

NORTH CAROLINA PRE-K 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) ____Child Support ____Statement from Employer ____Statement from DSS
____ No Income Verification Statement ___ Income Verification Statement ____ 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: _____
City: _____ ***State:*** _____ ***Zip:*** _____

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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 Early Head Start, Head Start and/or North Carolina Pre-K 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:

❑ **Child's Birth Certificate (Certificate, Medical, Family Bible)**	❑ **Food Stamp Card, if applicable**
❑ **Child's Medicaid card or Private Insurance card**	❑ **Proof of Income (current pay stub, LES, child support, other)** **For Head Start Only – need verification for previous 12 months** **(Acceptable verification includes: W-2 forms, tax returns, original pay stubs, letter from employer, or letter from DSS)**
❑ **Child's Immunization Record**	❑ **AFDC/TANF (Letter stating award of money received), if applicable**
For Office Use only: ❑ **Physical Date: _____ H _____ V_____**	❑ **Verification of child's special needs if applicable (Complete and current IEP, Medical Records, Letter from appropriate organization)**
	❑ **Other**