

2019-2020 CHILD'S APPLICATION



Location Preference: Office Use Only

A: CHILD INFORMATION

Child's Full Name		Date of Birth	
Child's Street Address	City	NC	ZIP
Which of the following best describes your family's living situation? <input type="checkbox"/> Permanent <input type="checkbox"/> Transitional or Emergency Shelter <input type="checkbox"/> Hotel/Motel/Campground <input type="checkbox"/> Lack of Permanent Nighttime Address			
Child's Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Child's Race/Ethnicity (Check All that Apply. Must Check One.) <input type="checkbox"/> White or European American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian			
Hispanic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is the child a N.C. resident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is the child a U.S. citizen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What language does the child speak at home?			
Is child currently attending a child care, preschool or half-day program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, what is the name of the program?			
Has the child ever been in a child care/preschool setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, location and dates served?			
Is the child currently being served at this site?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the child receive a child care subsidy voucher?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is at least one parent or legal guardian of this child an active duty member of the military or was seriously injured or killed while on active duty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do any of the following additional factors apply to this child? (Check all that apply) <input type="checkbox"/> Identified disability (indicated by the child having a current Individualized Education Plan – IEP) <input type="checkbox"/> Chronic health conditions (indicated by a health care provider, e.g. asthma, sickle cell anemia, cancer, HIV, etc.) <input type="checkbox"/> Developmental educational need (as indicated by the child's performance results on a developmental screening)			

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B: PARENT/GUARDIAN INFORMATION Please list only the parents/stepparents/caregiver that live in the home with the child applicant.

PRINT PARENT/GUARDIAN NAME 2 HERE:

Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relationship to Child	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
<input type="checkbox"/> Other, please specify (example: grandparent, stepparent, caregiver)		
Phone Number	Work Phone Number	
E-mail Address		
Please check all that apply <input type="checkbox"/> Not Employed <input type="checkbox"/> Employed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Attending Secondary Education <input type="checkbox"/> Attending Job Training <input type="checkbox"/> Attending High School/GED		
If employed, how often do you receive a paycheck? <input type="checkbox"/> Monthly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly		

PRINT PARENT/GUARDIAN NAME 2 HERE:

Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relationship to Child	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
<input type="checkbox"/> Other, please specify (example: grandparent, stepparent, caregiver)		
Phone Number	Work Phone Number	
E-mail Address		
Please check all that apply <input type="checkbox"/> Not Employed <input type="checkbox"/> Employed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Attending Secondary Education <input type="checkbox"/> Attending Job Training <input type="checkbox"/> Attending High School/GED		
If employed, how often do you receive a paycheck? <input type="checkbox"/> Monthly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly		

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Annual family income. (Attach supporting documentation for all income identified for each parent/guardian.)	
<input type="checkbox"/> Income before taxes	\$
<input type="checkbox"/> Alimony	\$
<input type="checkbox"/> Child support	\$
<input type="checkbox"/> Workers Comp	\$
<input type="checkbox"/> Unemployment	\$
<input type="checkbox"/> SSI/TANF/Work First	\$
<input type="checkbox"/> TOTAL Office Use Only	\$

With whom does the child live?
 Both Parents Other, please specify:
 Father Only
 Mother Only

What is the family size? (Include the child and all adults and other children living in the household.)

Please list the additional family members of the child that live in the home and are supported by the parent/caregiver's income.

1. Name	5. Name
Relationship to Child	Relationship to Child
Date of Birth	Date of Birth
2. Name	6. Name
Relationship to Child	Relationship to Child
Date of Birth	Date of Birth
3. Name	7. Name
Relationship to Child	Relationship to Child
Date of Birth	Date of Birth
4. Name	8. Name
Relationship to Child	Relationship to Child
Date of Birth	Date of Birth

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C: DEVELOPMENTAL ASSESSMENTS

Is the family concerned about the child's development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:		
Has the child been referred for an evaluation or identified with a disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>What was the decision of the evaluation for this child?</p> <p><input type="checkbox"/> No disability identified</p> <p><input type="checkbox"/> Evaluation decision in process</p> <p><input type="checkbox"/> One or more disabilities identified</p> <p><input type="checkbox"/> Do not know</p> <p><input type="checkbox"/> Not Applicable</p>		
<p>What conditions were identified? (Please check all that apply.)</p> <p><input type="checkbox"/> Autistic</p> <p><input type="checkbox"/> Hearing Impaired</p> <p><input type="checkbox"/> Orthopedically Impaired</p> <p><input type="checkbox"/> Severely/Profoundly Mentally Disabled</p> <p><input type="checkbox"/> Speech/Language Impaired</p> <p><input type="checkbox"/> Visually Impaired</p> <p><input type="checkbox"/> Behaviorally/Emotionally Disabled</p> <p><input type="checkbox"/> Multi-Handicapped (please explain)</p> <p><input type="checkbox"/> Preschool/Persistent Developmentally Delayed</p> <p><input type="checkbox"/> Other Health Impaired</p> <p><input type="checkbox"/> Not Applicable</p>		
Has the child been referred for services? (Speech, Physical, Occupational Therapy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child receiving services related to the disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list:		
Does the child have an active IEP (Individualized Education Plan)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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D: NC PRE-K LOCATION CHOICES

1st Choice	2nd Choice	3rd Choice	No Preference

E: CERTIFICATION & SIGNATURE

By signing this form, I certify that the information provided is true, correct, and complete and that all income has been reported. Program staff may verify information on this Application.

I give permission for the NC Pre-K site my child attends to share my child's medical screening, developmental screening and formative assessment results with Smart Start of Transylvania County.

Adult Signature	Today's Date
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F: APPLICATION CHECKLIST

Did you remember to:

- Sign and date the application
- Include proof of child's birth date
- Include proof of family income for all working parents/caregivers
- If child is in foster care, include placement documentation
- If child has an IEP, include a copy of the IEP

Child applications and supporting documentation should be returned via email or mail to:

Smart Start of Transylvania County
Attn: NC Pre-K
PO Box 1676
Brevard, NC 28712

Email To:
reccasnurr@smartstarttransylvania.org

Questions: Please call Rebecca Snurr at (828) 877-3025