APPLICATION CHECKLIST FOR ABC PRESCHOOL / HIPPY Program

_____ 1. Completed and dated application form

_____ 2. Documentation of child eligibility – 1 of the following required verifying income:
A months worth of consecutive paystubs dated within the last 30 days; 2021 Federal Income Tax Form 1040 ; 2021 Form W-2 (box 1); for self-employed or farmers – 2021 Tax Form 1040 and Schedule C or Schedule F ;
documentation showing current eligibility for food stamps stamp benefits or Medicaid ARKids A (must be dated within 30 days of application registration); letter from DHHS caseworker verifying household income.
No earned income statement signed & notarized.

_____ 3. Copy of birth certificate, or hospital record or other official verification of birth date.

_____ 4. Copy of Immunization record or proof of current immunizations.

_____ 5. Copy of child's social security card.

_____ 6. Copy of a current utility bill with physical address on it.

Has/is your child enrolled in another ABC preschool program or a HIPPY program? Yes _____ No _____
If yes, please list the name of the preschool or HIPPY program.
_____

********There will be an enrollment packet of forms to be completed upon acceptance into the program

Arkansas Better Chance Program
PO Box 1437, Slot S-160
Little Rock, AR 72203

Primary Caregiver Application

First Name:	**Middle Initial:**		**Last Name:**	
Gender: ☐ Male ☐ Female	**Application Date:**	**MM-DD-YYYY** / /	**Birth Date:**	**MM-DD-YYYY** / /
Do you receive food stamps? ☐ Yes ☐ No		SNAP # :		
Ethnicity: ☐ Hispanic ☐ Yes, Cuban ☐ Yes, Puerto Rican ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Other Spanish, Hispanic, Latino	**Race:** ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Chinese ☐ Black or African American ☐ Filipino ☐ Guaanian or Chamorro ☐ Other ☐ Immigrant ☐ Japanese ☐ Korean ☐ Migrant ☐ White ☐ Multi-Racial ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other, Pacific Islander ☐ Unknown ☐ Vietnamese			
Education Level: ☐ Bachelor or Advance Degree ☐ College degree or training school certificate ☐ ESL ☐ GED ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ Grade 9 or less ☐ High School Graduate ☐ No High School ☐ Some College/Vocational/AA Degree ☐ Some High School ☐ Unknown				
Employment Status: ☐ Farmer ☐ Full-time & training ☐ Employeed Full-time ☐ Homemaker ☐ Job training/school/Part-time ☐ Migrant Farm Worker ☐ Part-time & training ☐ Employeed Part-time ☐ Retired or Disabled ☐ Self-Emplyeed ☐ Unemplyeed ☐ Seasonal Worker ☐ Unknown				
Member of U.S. Military on active duty? ☐ Yes ☐ No				
Employer / school name:			**Work Phone # :**	
Home Phone #:	**Cell #:**		**email:**	
Home Address:	**City:**		**State:**	**Zip:**
County:	**Township:** ☐ Metropolitan ☐ Rural ☐ Urban			
# in family:	**# in household:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Medical Insurance: ☐ Yes ☐ No	**Insurance Company:** ☐ Aetna Global Benefits ☐ AHA Care ☐ Ambetter ☐ ARKids 1st ☐ ARKids A ☐ ARKids B ☐ Blue Advantage ☐ Blue Cross Blue Sheild ☐ CareFirst ☐ Cigna ☐ Medicaid ☐ Medicare ☐ Private Health Coverage ☐ QualChoice ☐ TriCare ☐ UnitedHealth Care			
Disabled: ☐ Yes ☐ No	**Current Housing:** ☐ Own ☐ Rent ☐ Homeless ☐ Other		**Current Housing Date:**	
Has the family moved in the last 24 monthes? ☐ Yes ☐ No				
Primary Caregiver Income:	$	☐ Monthly ☐ Weekly ☐ Bi-Weekly ☐ Semi-monthly ☐ Yearly		

Primary Caregiver Signature:_____ **Date:**_____

I declare that under the penalty of perjury and the rules and regulations of the Arkansas Better Chance Program that the sullpied information 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.

Secondary Caregiver Application

First Name:	Middle Initial:	Last Name:

Gender: □ Male □ Female	Application Date:	MM-DD-YYYY / /	Birth Date:	MM-DD-YYYY / /

Do you receive food stamps? □ Yes □ No SNAP # :

Ethnicity:
□ Hispanic □ Yes, Cuban
□ Yes, Puerto Rican
□ Yes, Mexican, Mexican American, Chicano
□ Yes, Other Spanish, Hispanic, Latino

Race: □ American Indian or Alaskan Native □ Asian Indian
□ Chinese □ Black or African American □ Filipino
□ Guaanian or Chamorro □ Other □ Immigrant □ Japanese
□ Korean □ Migrant □ White □ Multi-Racial □ Native Hawaiian
□ Other Asian □ Samoan □ Other, Pacific Islander □ Unknown
□ Vietnamese

Education Level: □ Bachelor or Advance Degree □ College degree or training school certificate □ ESL □ GED
□ Grade 10 □ Grade 11 □ Grade 12 □ Grade 9 or less □ High School Graduate □ No High School
□ Some College/Vocational/AA Degree □ Some High School □ Unknown

Employment Status: □ Farmer □ Full-time & training □ Employeed Full-time □ Homemaker
□ Job training/school/Part-time □ Migrant Farm Worker □ Part-time & training □ Employeed Part-time
□ Retired or Disabled □ Self-Emplyeed □ Unemplyeed □ Seasonal Worker □ Unknown

Member of U.S. Military on active duty? □ Yes □ No

Employer / school name:	Work Phone # :

Home Phone #:	Cell #:	email:	
Home Address:	City:	State:	Zip:

County:	Township: □ Metropolitan □ Rural □ Urban	
# in family:	# in household:	Marital Status: □ Single □ Married □ Divorced □ Widowed

Medical Insurance:
□ Yes □ No

Insurance Company: □ Aetna Global Benefits □ AHA Care □ Ambetter
□ ARKids 1st □ ARKids A □ ARKids B □ Blue Advantage □ Blue Cross Blue Sheild
□ CareFirst □ Cigna □ Medicaid □ Medicare □ Private Health Coverage
□ QualChoice □ TriCare □ UnitedHealth Care

Disabled: □ Yes □ No	Current Housing: □ Own □ Rent □ Homeless □ Other	Current Housing Date:

Has the family moved in the last 24 monthes? □ Yes □ No

secondary Caregiver Income:	$	□ Monthly □ Weekly □ Bi-Weekly □ Semi-monthly □ Yearly

Secondary Caregiver Signature:_____ **Date:** _____

I declare that under the penalty of perjury and the rules and regulations of the Arkansas Better Chance Program that the sullpied information 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.

Child Eligibility Application

First Name:	Middle Initial:	Last Name:
Application Date: MM-DD-YYYY / /	Gender: □ Male □ Female	Birth Date: MM-DD-YYYY / /

Demographic Information

Primary Language:	Other Language:
Speak English at home? □ Yes □ No	English Skills: □ Very Well □ Well □ Not Well □ Not At All
Ethnicity: □ Hispanic □ Yes, Cuban □ Yes, Puerto Rican □ Yes, Mexican, Mexican American, Chicano □ Yes, Other Spanish, Hispanic, Latino	Race: □ American Indian or Alaskan Native □ Asian Indian □ Chinese □ Black or African American □ Filipino □ Guaanian or Chamorro □ Other □ Immigrant □ Japanese □ Korean □ Migrant □ White □ Multi-Racial □ Native Hawaiian □ Other Asian □ Samoan □ Other, Pacific Islander □ Unknown □ Vietnamese
SSN:	Other ID: / US Citizen: □ Yes □ No

Eligibilty Information

Parental Status: ◯ Two Parent ◯ Single Parent

□ Teen Parent □ Disabled Parent □ Foster Parent □ Active Male □ Homeless □ Guardian

□ Group Home □ Dual Custody □ Student Parent □ Migrant Parent □ Grandparent

□ Previously in Foster Care

Relation to Primary Caregiver:

Relation to Secondary Caregiver:

Additional Eligibilty Information

□ Special Needs **Disability Status:** □ No □ Suspected □ Certified IEP □ Certified IFSP

□ Child Protective Services □ Non-English Speaking/LEP □ Incarcerated Parent □ Active Duty

□ Non-parental custody/not living with mother/father □ Arrested/Convicted of Drug Offense

□ No High School Diploma □ Waiver □ Low Birth Weight □ Parent < 18 yrs of age at birth

□ Substance abuse/neglect/victim □ Parents cannot read □ Title I □ IDEA

□ Developmental Delay □ Completed H3 □ Completed H4 □ Completed H5

□ Enrolled in HIPPY Year 1 □ Enrolled in HIPPY Year 2 □ Enrolled in HIPPY Year 3

Medical Insurance: □ Yes □ No	Medicaid Number:
Current School District (where child resides):	
Did child receive services before classes began in the current school year? □ Yes □ No	
Signature _____	Date: _____
Signature _____	Date: _____

I declare that under the penalty of perjury and the rules and regulations of the Arkansas Better Chance Program that the sullpied information 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.

Arkansas Better Chance Program

Student Name: _____ **Date:** _____

*Allergies or Special dietary needs: _____

*Is this child enrolled in a daycare or preschool program at this time? Yes / No
If so, where _____

*Has this child attended a state-funded pre-K (ABC) program before? Yes / No
If so, Where? _____

* Are you concerned that your child may have a disability (such as a speech delay or a developmental delay)? If so, please list your concerns: _____

*Does your child receive any special services or have a current IEP? If so, please list:
_____

*Alternative contact person (Name & #):_____

Arkansas Better Chance Program

Student Name: _____ **Date:** _____

Household information:

* Number in immediate family (parent/guardian/siblings): _____

* Number in household (total number of people living in the house): _____

----------*Please list all of these people below: Use back if needed*----------

PLEASE LIST ALL PEOPLE WHO ARE LIVING IN THE HOUSE:

NAME (please list child also)	RELATIONSHIP	

*Allergies or Special dietary needs: _____

*Is this child enrolled in a daycare or preschool program at this time? Yes / No
If so, where _____

*Has this child attended a state-funded pre-K (ABC) program before? Yes / No
If so, Where? _____

* Are you concerned that your child may have a disability (such as a speech delay or a developmental delay)? If so, please list your concerns: _____

*Does your child receive any special services or have a current IEP? If so, please list:
_____

*Alternative contact person (Name & #):_____

CONTINUE ON THE OTHER SIDE

Division of Child Care and
Early Childhood Education

Student insurance information: Does the student have medical insurance? Yes ___ No ___

STUDENT PRIMARY INSURANCE **********

Insurance Company: PLEASE CHOOSE ONE

_____ AHA Care
_____ ArKids 1st
_____ ArKids A
_____ ArKids B

____ Blue Advantage
____ Blue Cross Blue Shield
____ CareFirst
____ Cigna

____ Medicaid
____ Medicare
____ Private Health Coverage
____ QualChoice
____ TriCare
____ United Health Care

Other: _____

STUDENT SECONDARY INSURANCE (if applicable) **********

Insurance Company: PLEASE CHOOSE ONE

_____ AHA Care
_____ ArKids 1st
_____ ArKids A
_____ ArKids B

____ Blue Advantage
____ Blue Cross Blue Shield
____ CareFirst
____ Cigna

____ Medicaid
____ Medicare
___ Private Health Coverage
____ QualChoice
____ TriCare
____ United Health Care

Other: _____

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	
☐ AR Kids A	☐ Private Insurance
☐ AR Kids B	☐ 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.	☐	☐	Do you have any concerns about your child's general health?
2.	☐	☐	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	☐	☐	Does your child have any allergies (like to food, medicine, dust)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury?
7.	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	☐	☐	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	☐	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☐	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 _____

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:
This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight	Height	BMI	Temp	Blood Pressure
lb. %ile	in. %ile	%		/

History Update

☐ Yes ☐ No Any changes in patient health since last visit? Explain:_____
☐ Yes ☐ No Any family history of heart disease for anyone under 55 years of age?
☐ Yes ☐ No Any family history of abnormal cholesterol?

Health

☐ Good appetite
☐ Drinks lowfat milk
☐ Encourage diet of fruit and vegetables
☐ Limits fast food
☐ Picky or variable eater
☐ Brushes teeth, sees dentist

Social and Behavioral

☐ Parents discipline appropriately
☐ Dresses self, helps at home
☐ TV and video games are limited
☐ Praised for good behavior
☐ Has friends and playmates

PHYSICAL EXAM

	Norm	Abnormal
General	☐	☐
Head	☐	☐
Neck	☐	☐
Eyes	☐	☐
Ears	☐	☐
Nose	☐	☐
Throat	☐	☐
Mouth	☐	☐
Teeth	☐	☐
Lungs	☐	☐
Heart	☐	☐
Femoral Pulses	☐	☐
Genitals	☐	☐
Extremities	☐	☐
Gait	☐	☐
Spine	☐	☐
Skin	☐	☐
Neuro	☐	☐

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L_____ R_____		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

Immunizations

☐ Yes ☐ No All immunizations are current.
☐ Yes ☐ No Child has had all immunizations possible at this time.
Child needs: ☐ DTaP ☐ IPV ☐ HepB ☐ HiB ☐ MMR ☐ Varivax ☐ PCV-7 at _____years/_____ months

Referrals

☐ Follow up visit needed in _____ weeks / months
☐ Return check at _____ years _____ months
☐ Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions

☐ Well child, normal growth and development
☐ _____

_____, MD / DO / NP
Date_____

CLINIC INFORMATION (or stamp)

Name_____
Address_____
City_____
Zip Code_____ Phone_____