2019-2020 SCHOOL YEAR

IMPORTANT INFORMATION REGARDING THE ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS ENROLLMENT PROCESS

It is extremely important that each item on the registration checklist is turned in along with the application. If we do not receive each document on the checklist, your child's application will not be considered for enrollment. Once complete application packets are submitted, they will be reviewed and it will be determined if your child qualifies for the ABCSS Pre-K Program.

Tentatively, acceptance letters will be sent out in June 2019

Thank you!

PLEASE RETURN COMPLETED APPLICATION & DOCUMENTS TO:

Dawson Education Cooperative
Attn: ABCSS Pre-K Program
711 Clinton Street
Arkadelphia, AR 71923
PHONE: 870-246-1450
FAX: 870-246-1457

DAWSON CO-OP ABCSS PRE-K APPLICATION PACKET

ALL DOCUMENTS BELOW MUST BE COMPLETE BEFORE APPLICATION IS CONSIDERED

- ☐ ABC Child Application
- ☐ Copy of Child's Birth Certificate
- ☐ Copy of Child's Social Security Card
- ☐ Current Immunization Record
- ☐ Proof of Income: Please provide one of the following for each caregiver
  - 30 days current paystubs
  - Income Tax Form (2018)
  - W2 (2018)
- ☐ If Unemployed:
  - Notarized statement signed stating that there is no earned income at this time
- ☐ Additional Eligibility Information (Documents required)
  - Foster child
  - Child with an incarcerated parent
  - Child in the custody of/living with a family member other than mother or father
  - Child with immediate family member arrested for or convicted of drug-related offenses
  - Child with a parent activated for overseas military duty
- ☐ Proof of Residency
- ☐ Dental Form
- ☐ Well Child Screening Form (will receive form with acceptance letter)
- ☐ USDA Food Program Eligibility Form(will receive form with acceptance letter)
- ☐ Screening Packet

With the signature(s) below, I agree that the above requirements are completed and that all information is accurate. I understand that the submission of false documentation to receive ABC services may result in exclusion from participation in any DHS program (including Medicaid) and referral for criminal prosecution.

Child's Name: _____ School District Residing In: _____

Parent Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date completed: _____

Items needed:

___ ABC Child Application
___ Birth Certificate
___ Social Security Card
___ Immunization Record
___ Proof of Income
___ Proof of Residency
___ Dental Form
___ Well Child Screening Form
___ Food Program Eligibility Form

PLEASE RETURN COMPLETED APPLICATION & DOCUMENTS TO:

Dawson Education Cooperative
Attn: ABCSS Pre-K Program
711 Clinton Street
Arkadelphia, AR 71923
PHONE: 870-246-1450
FAX: 870-246-1457

Student Name:_____
School District Residing In:_____

FOR OFFICE USE ONLY
School District:_____
Assigned Class:_____
Tuition Fee:_____
Date Enrolled:_____

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

PRIMARY CAREGIVER INFORMATION

(Parent or guardian with most contact with child)

Primary Caregiver Name (First/Middle/Last):_____

Date of Birth:_____ Cell/Home Phone:_____ Work Phone:_____

Gender:_____ Ethnicity/Race:_____ Primary Language:_____

Current address:_____

City:_____ State:_____ Zip Code:_____

Mailing address (if different):_____

Current Housing: Homeless_____ Own_____ Rent_____ Other_____

Current Housing Date:_____

Employment Status (Full Time/Part Time):_____ Employer Name:_____

Education Level (High school, college, etc.):_____ If attending school, where:_____

Annual income from Work sources:_____

Secondary CAREGIVER INFORMATION

(2nd Parent or guardian in household with child and is used for determining eligibility)

Secondary Primary Name (First/Middle/Last):_____

Date of Birth:_____ Cell/Home Phone:_____ Work Phone:_____

Gender:_____ Ethnicity/Race:_____ Primary Language:_____

Current address:_____

City:_____ State:_____ Zip Code:_____

Current Housing: Homeless_____ Own_____ Rent_____ Other_____

Current Housing Date:_____

Employment Status (Full Time/Part Time):_____ Employer Name:_____

Education Level (High school, college, etc.):_____ If attending school, where:_____

Annual income from Work sources:_____

HOUSEHOLD INFORMATION

Number in family (#of immediate family members living in the house. (Parent, Guardian, Siblings):_____

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

List the name and relationship to the child enrolled of all family members in the household:

Name:	Relationship:

CHILD INFORMATION

Name (First/Middle/Last):_____

Date of Birth:_____Social Security Number:_____

Gender:_____Ethnicity/Race:_____Primary Language:_____

Has the child attended state-funded Pre-K (ABC) program before: Yes_____No_____

If so, where?_____

Will this child be enrolled in a HIPPY Program (Home Instruction for Parents of Preschool Youngsters)? Yes___No___

If so, which HIPPY Program?_____

List any allergies:_____

Does the child have any special dietary needs?_____

Is the child receiving any special education services?_____

Medical Insurance (for child): ___ Yes ___No

Specify:___ Aetna Global Benefits ___ AHA Care ___ Ambetter ___ ARKids 1st ___ ARKids A ___ ARKids B
___ Blue Advantage ___ Blue Cross Blue Shield ___ CareFirst ___ Cigna ___ Health Network for Louisiana
___ Medicaid ___ Medicare ___ Private Health Coverage ___ QualChoice ___ TriCare
___ United Healthcare

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:_____

Child's Name:_____

School:_____

Date of child's last Dental exam?_____

Month/Date/Year

Name of Dentist?_____

Name of Clinic?_____

Does your child have dental insurance?_____

What is the name of the insurance company?_____

Sliding Fee Scale-Up to 250% Federal Poverty Level (FPL) 2018

Family Size	up to 200%	up to 212.5%	up to 225%	up to 237.5%	up to 250%	Not eligible
1	$0 - $2023.33	$2023.34- $2149.79	$2149.80-$2276.25	$2276.26-$2402.71	$2402.72-$2529.17	$30,350.16
2	$0 - $2743.33	$2743.34-$2914.79	$2914.80-$3086.25	$3086.26-$3257.71	$3257.72-$3429.17	$41,150.16
3	$0 - $3463.33	$3463.34-$3679.79	$3679.80-$3896.25	$3896.26-$4112.71	$4112.72-$4329.17	$51,950.16
4	$0 - $4183.33	$4183.34-$4444.79	$4444.80-$4706.25	$4706.26-$4967.71	$4967.72-$5229.17	$62,750.16
5	$0 - $4903.33	$4903.34-$5209.79	$5209.80-$5516.25	$5516.26-$5822.71	$5822.72-$6129.17	$73,550.16
6	$0 - $5623.33	$5623.34-$5974.79	$5974.80-$6326.25	$6326.26-$6677.71	$6677.72-$7029.17	$84,350.16
7	$0 - $6343.33	$6343.34-$6739.79	$6739.80- $7136.25	$7136.26-$7532.71	$7532.72-$7929.17	$95,150.16
8	$0 - $7063.33	$7063.34-$7504.79	$7504.80-$7946.25	$7946.26-$8387.71	$8387.72-$8829.17	$105,950.16
FEE %	No Fee	20%	40%	60%	80%	Full Rate
Monthly Center/FH Fee (per child)	$0	$97.20	$194.40	$291.60	$388.80	$486

ABC Required Screening Packet

Please fill out each page

Your child will be screened in the following areas:

*Speech *Vision *Hearing *General Development

Dawson Education Service Cooperative
Early Childhood Special Education Department
711 Clinton Street, Suite 201
Arkadelphia, AR 71923
Office (870) 246-7928 Fax (870) 246-3130

Screening Consent Form

Child's Name: (Full Legal Name)_____
First Middle Last (Nickname)

Child's Social Security Number (REQUIRED): _____-_____-_____ **School District** _____

Does your child receive Medicaid/ARKids? Yes ☐ No ☐ If yes, Medicaid Number _____

Date of Birth _____ Age _____ Sex: Male ☐ Female ☐

Race: (check all that apply): African American (Black) ☐ White ☐ Asian ☐ Hispanic ☐

American Indian/Native American ☐ Native Hawaiian/Pacific Islander ☐

County of Parent Residence: _____

Parent or Legal Guardian Name: _____
First Last

Address: _____ City: _____ State: _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Day Time Phone # _____ e-mail address: _____

Child's Primary Care Physician: _____ Clinic _____ Phone _____

Child attends (please circle one): Day Care / Head Start / Preschool / Mother's Day Out / Home Based

Center Information: _____
Name Address City Zip Phone

Name of Classroom Teacher _____

Has your child had any previous evaluations: Yes ☐ No ☐ Has your child received therapy: Yes ☐ No ☐

If yes to either of the above questions, please explain: _____

Are their any behavioral issues? If so, please explain: _____

Will an interpreter be needed? Yes ☐ No ☐ Language_____ or Hearing impaired: Yes ☐ No ☐
(specify lang.)

I give permission to have my child screened by Dawson Education Service Cooperative Special Services Program. The screening may include one or more of the following areas: speech, development, motor, vision and/or hearing. If you have any questions you may call 870-246-7928

Parent Signature for consent to screen: _____ Date: _____

For office use only: RCVD by _____ on ____/____/____

Revised August 2017

Parent/ Teacher Report and Scoring Form—Self-help and Social-Emotional Scales

A. Child's Name _____ Date of Screening _____ Year _____ Month _____ Day _____ School/Program _____

Parent(s)/Caregiver(s) _____ Birth Date _____ Teacher _____

Age _____ Examiner _____

Directions: Read each item and circle the response or description that best reflects the child's skill level.

SELF-HELP SKILLS

A. Eating Skills

1. Does _____ use a spoon?
If yes, does _____ place the spoon in his/her mouth without turning the spoon upside down, with little or no spilling of food?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

2. Does _____ use the side of the fork for cutting soft food, such as a piece of baked potato or a piece of cake?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

3. Does _____ hold a fork in his/her fingers, not in his/her fist?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for A. Eating Skills ___/3

B. Dressing Skills

4. Does _____ put on his/her shoes?
Criteria: Buckling, tying, or Velcro® fastening is not required for credit.

No = 0	Yes (sometimes on wrong feet) = 1	Yes (each shoe on correct foot 90% of the time) = 2	___/2

5. Does _____ dress himself/herself unsupervised?

Rarely/No = 0	Sometimes = 0	Most of the time, except for help with difficult fasteners = 1	
Yes (completely dresses himself/herself, putting all clothes on correctly and fastening all fasteners) = 2	Yes (completely dresses himself/herself, including tying shoelaces and fastening all fasteners) = 3		___/3

6. Does _____ put on his/her socks?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for B. Dressing Skills ___/6

C. Toileting Skills

7. Does _____ get on the toilet or potty by himself/herself (even if he/she needs help with clothing)?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

8. Does _____ have bowel movements ("poop") in the toilet or potty (no more than one accident a week)?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

9. Does _____ urinate ("pee") in the toilet or potty (no more than one accident a week)?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

10. Does _____ attempt to wipe himself/herself after toileting?

Rarely/No = 0	Sometimes = 0	Most of the time = 1

OR *(Answer only the more appropriate of these two questions.)*

Does _____ wipe himself/herself independently after toileting?

Rarely/No = 0	Sometimes = 0	Most of the time = 2	___/2

11. Does _____ take care of his/her toileting needs?

Rarely/No = 0	Sometimes = 0	Yes (flushing the toilet most of the time after using it) = 1	Yes (flushing the toilet and washing and drying his/her hands most of the time) = 2	___/2

12. Does _____ go to the bathroom on his/her own without being asked or reminded?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for C. Toileting Skills ___/8

TOTAL FOR SELF-HELP
(A. Eating Skills, B. Dressing Skills, C. Toileting Skills) ___/17

Self-help and Social-Emotional Scales *(continued)*

SOCIAL AND EMOTIONAL SKILLS

D. Relationships with Adults

13.	Does _____ respond with feelings of pride and enthusiasm when he/she earns positive feedback?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
14.	Does _____ look forward to sharing his/her feelings with you when he/she is happy?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
15.	Does _____ enjoy sharing information with you about himself/herself, such as things he/she likes, names of his/her family members or pets, or what he/she did over the weekend?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
16.	Does _____ share his/her thoughts and ideas with you?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for D. Relationships with Adults ___ / 4

E. Play and Relationships with Peers

17.	Does _____ have several friends but one who is a special or best friend?		
	No = 0	Yes = 1	___/1
18.	Does _____ have a best friend with whom he/she is close and who reciprocates by coming over for play dates or extending an invitation to a party?		
	No = 0	Yes = 1	___/1
19.	Does _____ play cooperatively in a large-group game, such as duck-duck-goose, tag, or kickball?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
20.	Does _____ give verbal directions or incorporate verbal directions into play activities?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for E. Play and Relationships with Peers ___ / 4

F. Motivation and Self-Confidence

21.	Does _____ maintain interest when engaged in a small-group activity or project?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
22.	Does _____ show that he/she likes to finish what he/she starts, perhaps by dawdling less than at an earlier age?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
23.	Does _____ approach new tasks with confidence and a "can-do" attitude?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
24.	Does _____ remain focused on what he/she has been asked to do even when there are minor distractions, such as a car making noise outside or someone tapping a pencil?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for F. Motivation and Self-Confidence ___ / 4

G. Prosocial Skills and Behaviors

25.	If supervised by an adult, does _____ take turns without undue objection?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
26.	Does _____ understand or accept the need to share and take turns, perhaps willingly taking turns even if he/she isn't asked to?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
27.	Does _____ ask an adult for permission before using things that belong to others or before engaging in an activity that may be restricted, such as going to the bathroom or leaving the classroom?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
28.	Does _____ react to a disappointment or failure in an acceptable manner by being a good sport and refraining from shouting or getting upset?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for G. Prosocial Skills and Behaviors ___ / 4

TOTAL FOR SOCIAL-EMOTIONAL
(D. Relationships with Adults, E. Play and Relationships with Peers, F. Motivation and Self-Confidence, and G. Prosocial Skills and Behaviors) ___ / 16

Self-help and Social-Emotional Scales

ADE-SPED
REQUIRED
FORM
AUG 2017

Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name: _____ **ID:** _____ **Date of Birth:** _____

Age: _____ **Grade:** _____ **Local Education Agency:** _____

Medicaid Number: _____

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are identified in their individualized education program (IEP). In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.
- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.
- I understand that this may include sharing information with DHS, contracted billing agents, and/or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.
- I understand that information to be released may include: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of service(s), times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child, unless revoked by me.
- I understand that I may revoke consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this form.

_____ _____
Parent or Guardian Signature Date

Is your child covered by private insurance? ☐ No ☐ Yes (If yes, please complete Third Party Liability Section)

Parental Consent to Release Personally Identifiable Information
Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Name: _____ **ID:** _____ **Date of Birth:** _____

Age: _____ **Grade:** _____ **Local Education Agency:** _____

Medicaid Number: _____

Information Related to Billing Third Party Insurance:
Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

☐ I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school.

☐ I give my permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:

Insurance Company: _____

Address: _____

Phone: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Social Security Number: _____

Policy Number: _____ Group Number: _____

_____ _____
Parent or Guardian Signature Date

Childs Name: _____

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

SELECTIONS:

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. _____
PHYSICIAN NAME

2. _____
PHYSICIAN NAME

3. _____
PHYSICIAN NAME

CHANGES:

I want to change my primary care physician because:

_____

_____

_____

_____

_____

_____

_____

_____
BENEFICIARY SIGNATURE (Parent/Guardian Signature)

_____
MEDICAID I.D. NUMBER

_____
DATE

DMS-2609 (Rev. 4/07)