Crowley's Ridge Cooperative ABC Program
Marion School District – Avondale Elementary Pre-K

APPLICATION PROCESS
CHILD MUST BE 4 BY AUGUST 1, 2020
AND MUST LIVE IN THE MARION SCHOOL DISTRICT

STEP 1

Complete pages the ABC Application and both the front and back of the Marion School District Enrollment Form attached to the back of this application. Bring the completed application (All parts must be completed including signatures and dates), along with acceptable proof of residency (examples listed on page 1) to the Marion visual and Performing Arts Elementary Office. For your convenience, income guidelines are listed on the back of this Application Process sheet. Some preschool spaces are also available for children with documented special needs who do not qualify under the income guidelines.

STEP 2

You need to turn in the following documents to complete the application. These documents are a birth certificate, social security card, shot record, physical and proof of income for one month. Proof of income is either the 2019 W2 or Check Stubs for 1 current month. All documents must be turned in before an application is considered complete.

STEP 3

When all of the requested documents have been received within the deadline, your child's eligibility for the program will be determined. You will be notified by mail if your child has been accepted in the Crowley's Ridge Cooperative ABC Pre-K Program at Marion Visual and Performing Art Elementary.

The application has to be filled out completely, do not leave anything blank.

For more information, you may contact:
Leann Lester, ABC Assistant Coordinator
870-588-6843
llester@crmail.k12.ar.us

Crowley's Ridge Cooperative ABC Program
Marion School District - Marion Visual and Performing Arts

Parent Contact Page

Child Name:_____
Child Birthdate:_____
Age of Child by Aug. 1 2020:_____

Parent or Guardian
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**

State Preschool Program Income Guidelines

2020-21 ABC Program Income Guidelines

Family Size	Maximum Income for the Family 200% of FPL
1	$24,980
2	$33,820
3	$42,660
4	$51,500
5	$60,340
6	$69,180
7	$78,020
8	$86,860
For each additional Person add	$4,420 per person

Crowley's Ridge Co-op ABC Preschool Program
School District Residency Approval Form

Marion School District

This form must be on file with the application before processing will begin.
Residency approval is made by the school district before a child is admitted to the preschool. **Proof of residency must in the parents/ guardian's name or verification will be conducted by the school district.**

Only the items listed below can be used as proof of residence and must be in the parent/guardian name of the child for which the application is being made. **One** of the following must be presented with the application as "Proof of Residence" in the Marion School District:

1. Current Electric Bill
2. Current Gas Bill
3. Water Bill (Both Sections)
4. Rent Receipt
5. Mortgage Receipt

Parent/Guardian name and address must appear on the bill.

Part I Completed by Parent or Guardian **Date**_____

Child _____ Date of Birth _____

Parent or Guardian _____

Apartment & Street Address _____

City _____ State _____ Zip _____

What proof of residency is supplied? (Electric bill, gas bill etc.)_____

Is proof of residency in parent/guardian's name _____ Yes _____No
If "No", see the Marion Visual and Performing Arts School front office for a "Verification of Residency" Form.

Optional Parent Comments

The information below is for the office to complete once the application has been submitted.
Part 2. Completed by School Only **Residency Approval Status**

Pending Home Visit _____ Visit requested by _____ Date _____
Home visits September – May 31. Afterwards visits will be in August.
Residency Approved _____ Approved by _____ Date _____

Residency claim denied _____ Authorized by _____ Date _____

Crowley's Ridge Cooperative ABC Program
Marion School District - Marion Visual and Performing Arts

The Arkansas Better Chance (ABC) program is a state funded program that provides free preschool services to children of low-income families who are 4 years old by August 1st and whose parent is a resident of the Marion School District. 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 the Marion School District?
____Yes No ____ Will this child be 4 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 the 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 the 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.

Signature of Primary Caregiver_____Date_____

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

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

CHILD_____ **SCHOOL**_____

PRIMARY CAREGIVER INFORMATION (PARENT OR GUARDIAN WITH MOST CONTACT)

Name (First/Middle/Last):_____
Caregiver Date of Birth:_____ Home Phone:_____
Current Address:_____
City:_____ State:_____ 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 _____ Only Completed Up to Grade_____
College Diploma_____ 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)

Name (First/Middle/Last):_____
Caregiver Date of Birth:_____ Home Phone:_____
Current Address_____
City:_____ State_____ 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 _____ Only Completed Up to Grade_____
College Diploma_____ 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___
Ethnicity/Race_____
Is child U.S. Citizen? Yes ___ No___
Parental Status:
Single Parent___ Two Parent___ Guardianship___ Foster___ No Parent in Home___

EMERGENCY CONTACT AND CONSENT INFORMATION

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 _____

MARION SCHOOL DISTRICT

Phone: (870) 739-5100 | **K12 Enrollment Form** | **Fax: (870) 739-5156**

GENERAL STUDENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:

Birthdate:_____ Gender: Female Male

Nickname:_____ Grade:_____

SSN (Optional):_____ Hispanic/Latino Ethnicity: Yes No

RACE Please answer the following in accordance with standards issued by the US Department of Education.

PRIMARY RACE (Please select only **ONE**).

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment)
- ☐ **Asian** (A person having origins in any of the original peoples of Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)
- ☐ **White** (A person having origins in any of the original peoples of Europe, Middle East or North Africa)

ADDITIONAL RACES (check all that apply):

_____American Indian/Alaska Native _____Asian _____Black _____Native Hawaiian/Other Pacific Islander _____White

Siblings: _____ _____ _____

*Please only list school-aged siblings attending Marion Schools.

Language Spoken At Home:_____ Student Email Address:_____

Student Physical/911 Address

Address:_____

City:_____

State:_____ Zip Code:_____

Student Mailing Address

☐ Mailing Address is same as Physical/911 Address

Address:_____

City:_____

State:_____ Zip Code:_____

Student Home Phone:_____ Student Cell Phone:_____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1

Name:_____

Relationship to Student:_____

Language of Correspondence:_____

Mailing Address:_____

City:_____

State:_____ Zip Code:_____

Email:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ *Alert Phone:_____

*Alert Phone is used by the district's automated phone message system.

Employer:_____

☐ Student Primarily Resides with this Guardian.

Parent/Guardian 2

Name:_____

Relationship to Student:_____

Language of Correspondence:_____

Mailing Address:_____

City:_____

State:_____ Zip Code:_____

Email:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ *Alert Phone:_____

*Alert Phone is used by the district's automated phone message system.

Employer:_____

☐ Student Primarily Resides with this Guardian.

OFFICE USE ONLY

Entry Date:_____	Meal ST:_____	ESL:_____	IMMG:_____	Residency:_____
Entry Code:_____	M/V Act:_____	SP:_____	GT:_____	Choice LEA:_____
Curriculum:_____	504:_____	MIG:_____	Homeroom:_____	P/T ADM %:_____

City of Birth:_____ State of Birth:_____ Birth Country:_____

TRAVEL INFORMATION

Travel To School (Please check one)	**Travel From School** (Please check one)
____Bus (Bus Number_____)	____Bus (Bus Number_____)
____Drives Self	____Drives Self
____Parent/Guardian (includes walkers, child care vans, etc.)	____Parent/Guardian (includes walkers, child care vans, etc.)
____District Paid Transportation	____District Paid Transportation

Distance From Home to School (Miles) One Way:_____

Pre-School Participation:

A - ARKANSAS BETTER CHANCE	H - HEADSTART	O - OTHER
E - EVEN START	NA - NOT APPLICABLE	P - PRIVATE PRE-SCHOOL
EC - EARLY CHILDHOOD	C - 21st CENTURY COMMUNITY LEARNING CENTER	PS - PUBLIC SCHOOL PRE-SCHOOL

Resident County:_____

Is this child a dependent of an active or reserve member of a branch of the United States Armed Services? Yes No

If this child resides in a household with an active or reserve member of a branch of the United States Armed Services, please select the branch below.

____ Active Duty – US Army	____ Active Duty – US Air Force	____ Active Duty – US Navy	____ Active Duty – US Marines
____ Active Duty – US Coast Guard	____ Reserves – US Army	____ Reserves – US Air Force	____ Reserves – US Navy
____ Reserves – US Marines	____ National Guard – US Army	____ National Guard – US Air Force	____ Parents serve in multiple branches

Is this student a twin (or a triplet, quadruplet, etc.)? Yes No

ADDITIONAL CONTACT INFORMATION

Additional Guardian Contact

Name:_____ Email:_____

Relationship to Student:_____ Home Phone:_____ Cell Phone:_____

Language of Correspondence:_____ Work Phone:_____ *Alert Phone:_____

Mailing Address:_____ *Alert Phone is used by the district's automated phone message system.

City:_____ Employer:_____

State:_____ Zip Code:_____ ☐ Student Primarily Resides with this Guardian.

Emergency Information

Emergency Contact Information (Contacts Other Than Guardians to be Called in Case of an Emergency)

Contact Order	Name	Relationship to Child	Phone #	Phone Type (ex: Home, Cell, Work)
1				
2				
3				
4				
5				

Physician:_____ Physician:_____

Physician Phone:_____ Physician Phone:_____

Please list any medical concerns and/or medications for this child:_____

Last School Attended:_____ Phone #:_____

Address:_____

Has this child been expelled from school in any other school district or is the child a party to an expulsion proceeding? Yes No

Has this child been retained? Yes No

Has this child met the requirements of the Arkansas State Health laws necessary to enter school? Yes No

Please list the names of anyone who IS ALLOWED to check out/pick up this child from school: _____

_____ _____ _____

_____ _____

Parent/Guardian Signature Date