

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS CHILD APPLICATION

PRIMARY CAREGIVER INFORMATION (Parent or guardian with most contact with child)

*Name(First/Middle/Last):		
*Date of Birth:	Home Phone:	Work Phone:
*Current address:		
*City:	*State:	*ZIP Code:
*Employment Status (FT, PT):	Employer Name:	
Employment City:	State:	Employment Zip Code:
*# of hrs per week:	*Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
Annual Income From Work Sources or Unemployment:		

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

*Name(First/Middle/Last):		
*Date of Birth:	Home Phone:	Work Phone:
*Current address: <input type="checkbox"/> same as Primary Caregiver		
*City:	*State:	*ZIP Code:
*Employment Status (FT, PT):	Employer Name:	
Employment City:	Employment State:	Employment ZIP Code:
# of hrs per week:	Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
Annual Income From Work Sources or Unemployment:		

HOUSEHOLD INFORMATION

*Number in Family (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 and relationship to the child enrolled of all family members in the household:	
Name:	Relationship:

***Must be entered into COPA.**

CHILD INFORMATION

*Name(First/Middle/Last):		
*Date of Birth:	*Social Security Number:	
*Gender:	*Ethnicity:	*Primary Language:
Has this child attended a state-funded pre-K (ABC) program before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, where?	
Will this child be concurrently enrolled in an ABC center and HIPPPY or PAT program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, which HIPPPY or PAT?	
List any allergies:		
Does the child have any special dietary needs?		
Receiving any special education services?		
Primary Language:		

EMERGENCY CONTACT AND CONSENT INFORMATION

Name of emergency contact if parent/guardian cannot be reached:		
Address:	Phone:	
City:	State:	ZIP Code:
Relationship:		
Physician Name:		
Address	Phone:	
City:	State:	ZIP Code:
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	

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:

***Must be entered into COPA.**