NC Pre-K Program Child Application for 2025-2026

THE NORTH CAROLINA PRE-K PROGRAM

PARENTS – READ AND KEEP THIS INFORMATION SHEET

Your child may qualify for the NC Pre-K program, available through some schools, private sites, and Head Start childcare programs. Complete this form and return it to the site you obtained the application from. For assistance, talk with someone at the site or call 828-586-0661, extension 1040.

1. Complete this application in full. *Take Page 5, Program Eligibility Info Sheet, to your local Department of Social Services/Health Department/Public Housing Authority if your child or household receives any of the services listed on Page 5.* Return all completed materials, along with a copy of your child's birth certificate, to the Pre-K program where you obtained this application.
2. If your child does not receive any of the services on Page 5, submit the following income information for every parent/stepparent, custodian and guardian who is living in the same household as the Pre-K child:

a) First two pages of 2024 income tax return (1040); OR W2 forms for 2024; OR a minimum of one month's recent consecutive paycheck stubs which include the name of the payee, the pay period, gross and net wages, including overtime; **OR** a signed, dated statement from a person's employer on business letterhead stating the frequency of pay and gross wages, including overtime.
b) For self-employed individuals, provide Schedule C along with the first 2 pages of 2024 income tax return (1040). If taxes are not available, contact NC Pre-K Coordinator at ncprek@rapc.org for assistance.
c) Documentation of Per Capita/Indian Gaming Proceeds from 2024: check stubs **OR** 1099 Miscellaneous tax form bearing name of recipient; **OR** first 2 pages of 2024 income tax return (1040);
d) Documentation of child support payments for all minor children in household;
e) Alimony Award Letter (attach copy of court order) **OR** first 2 pages of 2024 income tax return (1040);
f) Workman's Compensation (attach copy of award letter) **OR** first 2 pages of 2024 income tax return (1040);
g) Retirement/disability benefit income (attach award letters from Social Security or Veteran's Admin);
h) Payment roster of all current Unemployment Benefits (including state and federal benefits).

What is NC Pre-K?

NC Pre-K provides eligible children/families with access to full-time, high-quality Pre-K services at school, Head Start and private childcare sites located in the western seven counties of North Carolina and on the Qualla Boundary. Classrooms operate for at least 6 ½ hours a day for ten months. A child who is approved for NC Pre-K and is placed in an NC Pre-K classroom may receive childcare for the NC Pre-K school day free of charge.

Who is Eligible for NC Pre-K?

A child is age eligible if s/he has turned four on or before August 31 of the program year but is not yet five years old. A family is eligible if they meet income guidelines. A family may be over the income guidelines and still be eligible for NC Pre-K assistance if one of the following applies: family is homeless; speaks a language other than English at home; is an eligible military family; or child exhibits an Educational Need, has an Individualized Education Plan or Chronic Health condition. Further documentation may be is required.

Contact the Region A Partnership for Children at
www.rapc.org
116 Jackson Street, Sylva, NC 28779
Phone 828-586-0661, ext. 1040
ncprek@rapc.org

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Printed name of person completing this application: ____

Your relationship to the Pre-K child:

Biological Parent ❒ Stepparent ❒ Other Family Member ❒ (relation) ___________
Legal Custodian ❒ Legal Guardian ❒ DSS Caseworker ❒ (county) ________________

If you are the child's legal custodian/guardian (other than the child's parent or stepparent) please attach the most recent court papers or authorization.

PLEASE *complete every portion of this application.*

Child's First, Middle, Last Name: ____ ❒ F ❒M

Child's Birth Date: _______/________/_________ **Copy of birth certificate MUST be attached**

Child's Home Address: ____

City: ___________________________________ **Zip**: _______________ **Phone**: ______________________________

What County Does Child Live In? (Circle one): Cherokee Clay Graham Haywood Jackson Macon Swain

Is child a North Carolina resident? Yes ❒ No ❒ **Is child a United States citizen?** Yes ❒ No ❒

Child's Ethnicity: *(check one)*: ______ Non-Hispanic ______ Hispanic

Child's Race: *(check all that apply)*: ______American Indian/Alaska Native ______Asian
______Black/African American ______Native Hawaiian/other Pacific Islander ______White/European American

HEALTH AND DENTAL EXAMINATIONS

Please take Page 6 of this application to your child's nurse or doctor, have it completed, and submit it with this application to the site where your child will enroll in Pre-K.

PICK ONE STATEMENT best describes your current childcare situation:

- ______ Child has never been in childcare
- ______ Child is currently unserved (at home now but has been in childcare or some preschool program)
- ______ Child stays with private babysitter or family member
- ______ My family pays for childcare (name of childcare center: ____________________________)
- ______ Child is in Head Start (name of Head Start center: ___________________________)
- ______ Child is in subsidized childcare (name of childcare center: ___________________________)

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Child's Full Name: ____

HOUSEHOLD & INCOME INFORMATION

List ONLY Parents/Stepparents/Custodians/Guardians Living in the Same Home with the Child

Income of parents/stepparents/custodians/guardians must be submitted with this application if a child does not qualify for services as listed on Page 5. See the *Information Sheet* that you received with this application for kinds of income that meet the requirements.

PARENT #1: ***Name of Parent/Stepparent/Custodian/Guardian***: ______________________________

Does this person live in the same household as the Pre-K child? Yes ❒ No ❒
Is this person legally married to Parent #2 listed on page 3? Yes ❒ No ❒

EVERY BOX BELOW MUST BE ANSWERED

Is This Person Employed? Yes ❒ No ❒
Seeking Employment? Yes ❒ No ❒
Disabled? Yes ❒ No ❒
Retired? Yes ❒ No ❒
In High School/GED Program Yes ❒ No ❒
In College? Yes ❒ No ❒

DO YOU RECEIVE ANY OF THE FOLLOWING?
(Attach income documentation for all items you answer 'Yes' to.)

Regular wages/employment income? Yes ❒ No ❒
Per Capita/Indian Gaming Proceeds? Yes ❒ No ❒
Alimony Payments? Yes ❒ No ❒
Unemployment Benefits? Yes ❒ No ❒
Workman's Compensation? Yes ❒ No ❒
Child Support for any minor children living in same home? Yes ❒ No ❒
Retirement income? Yes ❒ No ❒
Disability Income? Yes ❒ No ❒

ZERO INCOME STATEMENT – Complete the statement below ONLY if you are unemployed and have no income at all.

I, (print name) ______________________________ verify that I am NOT employed and receive NO income.

Signature ____ Date ______________________________

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Child's Full Name: ____

PARENT #2: Name of Parent/Stepparent/Custodian/Guardian: ______________________________

Does this person live in the same household as the Pre-K child? Yes ❒ No ❒
Is this person legally married to Parent #1 listed on page 2? Yes ❒ No ❒

EVERY BOX BELOW MUST BE ANSWERED

Is This Person Employed? Yes ❒ No ❒
Seeking Employment? Yes ❒ No ❒
Disabled? Yes ❒ No ❒
Retired? Yes ❒ No ❒
In High School/GED Program Yes ❒ No ❒
In College? Yes ❒ No ❒

DO YOU RECEIVE ANY OF THE FOLLOWING?
(Attach income documentation for all items you answer 'Yes' to.)

Regular wages/employment income? Yes ❒ No ❒
Per Capita/Indian Gaming Proceeds? Yes ❒ No ❒
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Child Support for any minor children living in same home? Yes ❒ No ❒
Retirement income? Yes ❒ No ❒
Disability Income? Yes ❒ No ❒

ZERO INCOME STATEMENT – Complete the statement below ONLY if you are unemployed and have no income at all.

I, (print name) ________________________________ verify that I am NOT employed and receive NO income.

Signature ____ Date ________________________________

LIST ALL OTHERS LIVING IN SAME HOME WITH CHILD DO NOT LIST PARENTS OR PERSONS WHO DO NOT LIVE IN THE SAME HOME WITH THE PRE-K CHILD		
NAME	RELATIONSHIP TO PRE-K CHILD	DATE OF BIRTH
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

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Child's Full Name: ____

PLEASE check all that apply:

____ We lack a fixed, regular and adequate nighttime residence (living with friend or relative, in a motel, shelter, tent, abandoned building or vehicle)

____ Limited English Proficiency (Family and/or child speaks limited or no English in the home)

____ Educational Need (attach copy of pages 1 & 2 of **current** IEP OR documentation of scores on recent developmental screening instrument as approved for use with NC Pre-K program)

____ Chronic Health Condition (Doctor's statement required)
Describe your child's health condition: ____

____ Eligible Military Families: Parent is: 1. An active duty member of the Armed Forces of the United States, including the North Carolina National Guard, State military forces, or a reserve component of the Armed Forces *who was ordered to active duty* by the proper authority within the last 18 months or is expected to be ordered within the next 18 months; or 2. A member of the Armed Forces of the United States, including the North Carolina National Guard, State military forces, or a reserve component of the Armed Forces who was injured or killed while serving on active duty. *Persons with service-connected disabilities must provide a current statement from the Veterans Administration indicating the percentage of disability they have, and monthly disability income.*

SIGN BELOW:

I certify that all information provided above is accurate to the best of my knowledge and I understand that providing false or inaccurate information may disqualify my child from receiving services.

Parent/Stepparent/Guardian/Custodian:

SIGN YOUR NAME: ____

PRINT YOUR NAME: ____

RELATIONSHIP TO CHILD: ____

TODAY'S DATE: ____

Please look over your child's application and make sure all areas have been completed. Take the attached Children's Medical Report form to your child's doctor for completion. You are welcome to contact the Region A Partnership for Children at 828-586-0661, extension 1040, or ncprek@rapc.org anytime! Check out our website at www.rapc.org!

Region A Partnership for Children
NC Pre-K Program Eligibility Info Sheet
2025-2026 School Year

1) CHECK OFF THE FORMS OF ASSISTANCE YOUR CHILD/HOUSEHOLD IS RECEIVING.
2) TAKE THIS FORM to an agency that provides one of the forms of public assistance you have checked. Have an agency representative complete, sign and date this form, verifying that your child or household is receiving this assistance.

Date ______________________

Child's Full Name __________________________ Child's DOB ______________

Type of Eligible Services (check all that apply):

______ Receiving Refugee Services

______ WIC

______ Medicaid

______ Public Housing

______ Supplemental Security Income (SSI)

______ Foster Care

______ Food & Nutrition Services and/or SNAP

______ TANF/Workforce

______ Other

TO BE COMPLETED BY AGENCY PERSONNEL ONLY – Parents do not complete this portion of form:

Printed Name of Person Verifying Services: ______________________________

Signature of Person Verifying Services: __________________________________

Contact Phone Numbers: ____

Agency Name: ____

Date: ____

Children's Medical Report

RAPC 2/2020

Name of Child ______________________________ Date of Birth ______________

Name of Parent/Guardian ____

Address of Parent/Guardian ____

A. Medical History (may be completed by parent/guardian)

1. Is child allergic to anything? No ___ Yes ____ If yes, what? ______________________________
   ____
2. Is child currently under a doctor's care? No ___ Yes ___ If yes, for what reason? _______________
   ____
3. Is child on any continuous medication? No ___ Yes ___ If yes, list diagnoses and medications: _______
   ____
4. Any previous hospitalizations or operations? No ___ Yes ___ If yes, when and for what? __________
   ____
5. Any history of significant previous diseases or recurrent illness? No ___ Yes ___ **Diabetes** No ___ Yes ___
   Convulsions No ___ Yes ___ **Heart Trouble** No ___ Yes ___ **Asthma** No ___ Yes ___
   If others, what and when? ____
6. Does child have any physical disabilities? No ___ Yes ___ If yes, please describe: _______________
   ____
7. Any behavioral/mental health concerns? No ___ Yes ___ If yes, please describe: _______________
   ____

B. Physical Examination: **This examination must be completed and signed by a licensed physician, his/her authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering states), a licensed Nurse Practitioner, or a licensed Public Health Nurse**

Height _____________ % Weight ____________ %
Head __________ Eyes __________ Ears __________ Nose __________ Teeth __________ Throat __________
Neck __________ Heart __________ Chest __________ Abd/GU __________ Ext __________
Neurological System ____________________ Skin __________ Vision __________ Hearing __________
Results of TB test, if given: Type __________ Date __________ Normal ___ Abnormal ___ Followup __________

Developmental Screening: Instrument used ____________________ Date Admin ____________________
Delayed __________ Age Appropriate __________ If delay, note significance and suggestions for care or follow-up: ____
Should activities be limited? No ___ Yes ___ If yes, explain: ________________________________
____
Other recommendations: ____

DATE OF EXAMINATION: _________________

Signature of Authorized Examiner/Title: ____________________________________
Name, Address of Agency or Medical Practice: ______________________________
____