2019-2020 ENROLLMENT APPLICATION

Received date: _____ Mo/Day/Yr

Plattsmouth Early Childhood Center
1912 Old Hwy 34
Plattsmouth, NE 68048
Phone: 402-296-5250
Fax: 402-296-5202

Program
___Sixpence ___Early Head Start
___Conestoga ___Plattsmouth ___Other

My family is applying for:

□ Home Based (prenatal to age 3)	□ Preschool (age 3 to age 5) □ Full Day □ Half Day

Applicant # 1

Applicant's Legal Name: Last	First
Date of birth:	Gender: □ Male □ Female
Birth weight: Was the child born before 37 weeks? □ Yes □ No	Primary language: Other languages spoken at home:
Ethnicity (choose one): □ Hispanic/Latino origin	□ Non-Hispanic/Non-Latino origin
Race: □ American Indian □ Asian □ Black □ Pacific Islander □ White □ Biracial/Multiracial □ Other	
Applicant is a pregnant woman: □ Yes □ No	If yes, expected due date:
Does the child have a special need or disability? □ Yes □ Suspected □ No ☐ IFSP? ☐ IEP? If yes, give diagnosis and source:	
Has the child been diagnosed by a physician to have any chronic medical diagnosis such as asthma, allergies, seizures, diabetes, etc.? □ Yes □ No If yes, please list:	
Was the child referred to program? □ Yes □ No (If yes, by whom?) (Why?)	
Were you referred for services by a child welfare agency? □ Yes □ No	
Does your child receive any of the following: Kid's Connection? □Yes □No Medicaid (not Kid's Connection)? □Yes □No Do you have private insurance? □Yes □No	
Do you have legal custody of this child? □ Yes □ No Type of Custody: □ Primary □ Joint * documentation of custody status may be required	

Applicant # 2

Applicant's Legal Name: Last	First
Date of birth:	Gender: □ Male □ Female
Birth weight: Was the child born before 37 weeks? □ Yes □ No	Primary language: Other languages spoken at home:
Ethnicity (choose one): □ Hispanic/Latino origin	□ Non-Hispanic/Non-Latino origin
Race: □ American Indian □ Asian □ Black □ Pacific Islander □ White □ Biracial/Multiracial □ Other	
Applicant is a pregnant woman: □ Yes □ No	If yes, expected due date:
Does the child have a special need or disability? □ Yes □ Suspected □ No ☐ ISFP? ☐ IEP? If yes, give diagnosis and source:	
Has the child been diagnosed by a physician to have any chronic medical diagnosis such as asthma, allergies, seizures, diabetes, etc.? □ Yes □ No If yes, please list:	
Was the child referred to program? □ Yes □ No (If yes, by whom?) (Why?)	
Were you referred for services by a child welfare agency? □ Yes □ No	
Does your child receive any of the following: Kid's Connection? □Yes □No Medicaid (not Kid's Connection)? □Yes □No Do you have private insurance? □Yes □No	
Do you have legal custody of this child? □ Yes □ No Type of Custody: □ Primary □ Joint * documentation of custody status may be required	

Family Information

Parental Status: □ One Parent □ Two Parent □ Foster Parent □ Non-Parent/Guardian	
Primary caregiver in household (name):	Number in immediate family:
Number in household:	Number of children by age: 0 to 3 ___ 4-5 ___ 5-over ___
Additional caregiver name:	Home address:
City: State:	Zip: County:
Mailing address: (If different than above):	City: State: Zip: County:
Phone: Home ( ) Work ( ) Cell ( ) E-Mail Address: Alternate contact name/phone #:	

Income Information is Required for Free or Reduced Programs

Names of all family members receiving income	HOUSEHOLD GROSS INCOME List last month's income below. Do not list hourly wage.				
Last Name, First Name	Earnings from work before deductions	TANF, child support, alimony	Pensions, retirement, Social Security	Other	NO Income
	$	$	$	$	□
	$	$	$	$	□
	$	$	$	$	□

******Please attach income verification documents (pay stub, W-2, tax documents, etc.)******

□**I choose not to submit income verification and understand that I will be required to pay the full preschool rate each month.**

Parent/Guardian's signature_____ Date _____

Other Information

Are any primary care givers under the age of 20? □ Yes □ No
Do any primary care givers have a disability or chronic physical, cognitive, or other health related condition or impairment? □ Yes □ No If yes, please specify:
Do any primary care givers have a mental illness? □ Yes □ No
Are any primary care givers incarcerated? □ Yes □ No
During the past 12 months has your employment or income changed? □ Yes □ No If yes, please specify:
Is your family in need or in crisis? □ Yes □ No If yes, describe:
Does anyone in your family receive: TANF or ADC: □ Yes □ No | WIC: □ Yes □ No | SSI: □ Yes □ No
Are you receiving Supplemental Nutrition Assistance Program (SNAP)? □Yes □ No
Is at least one parent/guardian a member of the United States military? □Yes □No If yes, is a parent/guardian currently deployed? □Yes □No

Family Member Information

First & last name of **ALL** family members living in the home	Date of Birth	Gender	Highest Grade Completed	Relationship to applicant
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		

Upon acceptance to a program, I understand that I will need to provide child's birth certificate, a current and complete immunization record, source of income verification, and current well child exam.

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian's signature_____ Date _____