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

APPLICATION PROCESS
CHILD MUST BE 4 BY AUGUST 1, 2026
AND MUST LIVE IN THE MARION SCHOOL DISTRICT

STEP 1

Complete pages of the ABC Application. Bring the completed application (All parts must be completed including signatures and dates), along with acceptable proof of residency (examples listed on page 3) 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 2025 W2 or Check Stubs for 1 current month. The physical must include: height, weight, hearing screening, vision screening, and a date. Copies of required documents will not be made at the school. 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

State Preschool Program Income Guidelines

2026-27 ABC Program Income Guidelines

Family Size	Maximum Income for the Family 200% of FPL
1	$31,920
2	$43,280
3	$54,640
4	$66,000
5	$77,360
6	$88,720
7	$100,080
8	$111,440
For each additional after 8 Person add	$5,680 per person

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 a 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 either parent NOT graduate high school?
____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 may result 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:_____ 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 _____ 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:_____ 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 _____ 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 at home? Yes___ No___
Ethnicity/Race_____
Is the child a 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**_____

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 2026:_____

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**

Arkansas Department of Human Services
Division of Child Care and Early Childhood Education

ARKANSAS BETTER CHANCE PROGRAM WELL CHILD SCREENING

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:_____

Crowley's Ridge Cooperative ABC Program

Eschool Form

Teacher Name:_____

Child Full Name:_____

Birth Date:_____

Race:_____ Sex:_____ Language:_____

Social Security Number:_____

Birth Certificate Number:_____
(Bottom Right Number)

Parent or Guardian Name:_____

Parent or Guardian Phone Number:_____

Parent or Guardian Name:_____

Parent or Guardian Phone Number:_____

Physical Address:_____

Emergency Contact Name and Number:

_____

Crowley's Ridge Cooperative ABC Program
1606 Pine Grove Lane
Harrisburg, AR 72432
Phone: 870-578-5426 FAX: 870-578-5896

Parent Request for Enrollment Transfer

As the parent/guardian of _____, I am requesting that the ABC COPA Specialist transfer my child's enrollment to the Marion Elementary ABC Site 29358 in the Crowley's Ridge Cooperative ABC Program from this date forward.

Child's Full Name: _____ Date of Birth: _____

Primary Caregiver: _____ Date of Birth: _____

Secondary Caregiver: _____ Date of Birth: _____

Name of Previous preschool attended: _____

Location of previous preschool: City _____ State _____

Approximate last date of attendance at previous preschool: _____

_____ _____

Parent's Signature Date

2026-2027 Employment Survey

School District / Building - Marion Preschool	Date / Fecha

Your child may qualify to receive <u>FREE SERVICES</u> such as: school supplies, school lunches, books, credit recovery, college scholarships and limited health services.	***Su hijo puede calificar para recibir: útiles escolares gratuitos, almuerzos escolares, libros, recuperación de créditos, becas universitarias y servicios de salud limitados.***

Student/Parent Information / Información del Estudiante / Padre

Student Name / Nombre del Estudiante	Birthday / Cumpleaños	Grade/ Grado
Parent Name / Nombre del Padre		
Address / Dirección	City / Ciudad	
Phone / Teléfono	Email / Correo Electrónico	
Place of Employment / Lugar de Empleo		

Relocation History/Historial de Reubicación

In the past three (3) years, have you or a member of your family with whom you reside, moved to live or stay temporarily in order to do agriculture work? (summer moves count)	☐ **Yes** **Si**	☐ **No** **No**	***En los últimos tres (3) años, ¿usted o un miembro de su familia con quien reside, se ha mudado a vivir o se ha quedado temporalmente para trabajar en la agricultura? (los movimientos de verano cuentan)***

If **YES**, what was the date of the move? / En caso afirmativo, ¿cuál fue la fecha de la mudanza?_____

If **YES**, please check the following agriculture job(s) that was done when the move was made.
En caso afirmativo, marque los siguientes trabajos agrícolas que se realizaron cuando se hizo la mudanza.

- ☐ **Working at a nursery** (planting, potting, pruning, transplanting) **/ Trabajar en un vivero** (plantar, podar, trasplantar)
- ☐ **Farming** (soil preparation, planting, harverstin, baling hay) **/ Agricultura** (preparación del suelo, siembra, cosecha, heno empacado)
- ☐ **Processing Plants** (meat, poultry, fruit, dairy, vegatables) **/ Plantas de procesamiento** (carnes, aves, frutas, lácteos, verduras)
- ☐ **Chicken Houses** (catching, caring for chickens, gathering eggs) **/ Gallineros** (captura, cuidado de pollos, recolección de huevos)
- ☐ **Cotton Gin** (building modules) **/ Desmotadora de algodón** (módulos de construcción)
- ☐ **Caring for livestock / Cuidando el ganado**
- ☐ **Commercial fishing or working on fish farm / Pesca comercial o trabajo en piscifactorías**
- ☐ **Chopping or pulling weeds / Cortar o arrancar las malas hierbas**
- ☐ **Growing or harvesting fruits,vegatables / Cultivar o cosechar frutas, verduras**
- ☐ **Working at a grainary, seed company** (cleaning, bagging) **/ Trabajar en una empresa de semillas , cereales** (limpieza, ensaca
- ☐ **Timber work** (planting, harvesting, cutting trees, skidding logs) **/ Trabajos de madera** (plantación, tala, tala de árboles, arrastre de troncos)

List all children in the household under 22 / Enumere todos los niños del hogar menores de 22 años

NAME /NOMBRE	BIRTHDAY/CUMPLEAÑOS	GRADE/GRADO