Little Badger Pre-K Application Procedures 2026-2027

Our Pre-K Program offers two types of classrooms. IF your family qualifies based on your household income/# in the family or other approved criteria, (see our District Pre-K page for more info) they will be in an ABC classroom. We have 80 ABC slots. IF your family does NOT qualify for one of these spots, we have 35 tuition ($110/week) slots.
The income guideline for an ABC qualification is included in the application.

- Complete each page of the paper application
- Provide copies of additional documents (see next page)
- TUESDAY, MARCH 17TH will be the FIRST day that we will accept applications. We will continue to accept applications until all spots are filled.
- Completed applications along with copies of required documents must be returned to our Pre-K office. We are located in the back of the Central Office Building.
- All applications will be dated and time stamped in the order that they are received.
- All available spots (ABC & tuition) are filled based on a FIRST COME/FIRST SERVED basis
- Once an application is processed, you will receive a letter in the mail giving you the status of your application.
- IF your application is not complete or you are missing necessary documents, this letter will have this information.
- Please make every effort to obtain missing documents and bring them to the Pre-K office so they can be added to your child's application.
- ONLY completed applications (along with documents) will be considered COMPLETE and OFFICALLY enrolled into Pre-K.

It is the responsibility of the enrolling parent/guardian to inform Little Badger Pre-K (501-882-5463 ext. 1117) if there are any changes in mailing address/phone number.

Copies of documents that must be included with application (tuition)

- Birth Certificate of enrolling child
- Social Security Card of enrolling child
- Current health screening (paperwork included in the application)
- An updated shot record OR a "catch-up" plan for your child

Our Pre-K day is from 7:30-2:30. If you require childcare outside of these hours, Beebe School offers a Before/After School program. Those hours are 6:15-6:00. There is an additional cost for this program.

ABC Pre-K
2026-2027
Projected Income Eligibility Levels

***to qualify for an ABC (tuition free) Pre-K classroom, your family income must not exceed the projected income levels for the number of people living in the household with the enrolling child (see table below)**

Family Size	Income Level
2	$43,280
3	$54,640
4	$66,000
5	$77,360
6	$88,720
7	$100,080
8	$111,440
9	$117,120
Each additional person add	$5,680

these income levels are subject to change prior to the start of the 2026-2027 school year

DIVISION OF ELEMENTARY & SECONDARY EDUCATION

School Readiness Application

All applicants must be eighteen (18) years and over or an emancipated minor. All applicants must have physical custody of the child(ren) for whom services are requested. If applying for Teen Parent, please enter Teen Parent's information below.

REQUIRED INFORMATION NEEDED FOR ALL PROGRAMS.

Parent or Guardian/Teen parent Information:

Social Security # (*Optional*)	First Name *(applicant)* MI Last Name	Date of Birth	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race (see codes):	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Primary Language:	Highest Level of Education or Training Completed:	Military Status (see codes):

# of Parents in home:	# in Family:	# of Household members:	Do you have household assets above $1,000,000? ☐Yes ☐No

Race Codes: A = Asian American B = Black/African American H = Hawaiian/Pacific Islander I = American Indian or Alaskan Native W = White/Caucasian O = Other

Military Status Codes: (Adults Only): N/A = No AD = Active Duty NGMR = National Guard/Military Reserve VUSM=Veteran of United States Military

Mailing Address	City/State	Zip	County	Home Phone/Cell:
Physical Address (if not the same)	City/State	Zip	County	Message Phone:

Current/Valid Email Address(required)

Second Parent or Guardian

Social Security # (*Optional*)	First Name MI Last Name	Date of Birth	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race (see codes):	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Primary Language:	Highest Level of Education or Training Completed:	Military Status (see codes):

Mailing Address	City/State	Zip	County	Home Phone/Cell:
Physical Address (if not the same)	City/State	Zip	County	Message Phone:

Have you ever received TEA or ESS? ☐ Yes ☐ No Have the child(ren) transitioned from foster care? ☐ Yes ☐ No	Do you have an open protective service case? ☐ Yes ☐ No Are you a Guardian or Custodian with physical custody? ☐ Yes ☐ No
Do you receive SNAP Benefits? ☐ Yes ☐ No Are you currently receiving WIC? ☐ Yes ☐ No Is any adult in household Disabled? ☐ Yes ☐ No	Current Housing: ☐Own ☐Rent ☐Homeless ☐Other Current Housing Date: Has your family moved in the past 24 months? ☐ Yes ☐ No
Check if applicable: ☐ Teen parent resides in the household. ☐ Teen parent is attending high school or GED program. ☐ Lacks regular, fixed, or adequate nighttime residence	☐ Shares housing due to economic hardship ☐ Lives in a shelter, hotel, or motel ☐ Lives in a place not designed for sleeping (cars, parks, etc.)

Please complete the chart below. List all adults and children (including the enrolling child) living in the household with the enrolling child. We will only need the Social Security number on the enrolling child. ALL other information on each member of the household must be completed.

Social Security #	First Name MI Last Name	Date of Birth:	Gender	Citizen/Legal Resident	Relationship to applicant:	Services Needed?	Race (see codes)	Military Status Adults only (see codes)
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		
			☐ Male ☐ Female	☐ Yes ☐ No		☐ Yes ☐ No		

EMPLOYMENT INFORMATION:

Name:	Employer:

Are you currently employed at a childcare facility who is a CCDF program participant? ☐Yes ☐No

Does your position with the program service birth to 5? ☐Yes ☐No

List work schedule below (List actual start/end times for each day) | Working Status: ☐Full Time ☐Part Time ☐Temporary ☐Seasonal

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Start Date:	Average Weekly Hours:	Estimated Daily Travel Time:

Name:	Employer:

Are you currently employed at a childcare facility who is a CCDF program participant? ☐Yes ☐No

Does your position with the program service birth to 5? ☐Yes ☐No

List work schedule below (List actual start/end times for each day) | Working Status: ☐Full Time ☐Part Time ☐Temporary ☐Seasonal

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Start Date:	Average Weekly Hours:	Estimated Daily Travel Time:

SCHOOL INFORMATION:

Name:	School:

☐ Currently attending GED program ☐ Currently attending high school ☐ Currently attending Higher Education or Job Skills Training Program

Start Date: End Date:	Hours Enrolled:	Student Status: ☐full time ☐part time	Major or course of study:

List school schedule below (List actual start/end times for each day) | Estimated Daily Travel Time:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Name:	School:

☐ Currently attending GED program ☐ Currently attending high school ☐ Currently attending Higher Education or Job Skills Training Program

Start Date: End Date:	Hours Enrolled:	Student Status: ☐full time ☐part time	Major or course of study:

List school schedule below (List actual start/end times for each day) | Estimated Daily Travel Time:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

HOUSEHOLD INCOME: Proof of ALL household income must be provided. List how often received; Weekly, Bi-Weekly, Twice Monthly, Monthly

Name of person(s) receiving:

Gross Wages		☐SSI ☐SSA		☐Commission ☐Bonus		Other: (Explain)	
Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often

Name of person receiving:

Gross Wages		☐SSI ☐SSA		☐Commission ☐Bonus		Other: (Explain)	
Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often

INFORMATION FOR CHILD(REN) SERVICES ARE REQUESTED

Child's Name	List any medical or developmental disabilities	Name of School Readiness Participant selected	List days and hours of care needed for the child	Child attends ABC or Head Start	School child currently attends
				☐ Yes ☐ No	

Medical Insurance
ARKids #
Does child have any special dietary needs? ☐ Yes ☐ No
List any allergies (food, insects, etc.):

Has child attended a state-funded Pre-K (ABC) program? ☐ Yes ☐ No
If so, where?
Will child be concurrently enrolled in an ABC center and HIPPY or PAT program? ☐ Yes ☐ No
If so, which HIPPY or PAT Program?
Does child receive any special education services? ☐ Yes ☐ No

Child's Name	List any medical or developmental disabilities	Name of School Readiness Participant selected	List days and hours of care needed for the child	Child attends ABC or Head Start	School child currently attends
				☐ Yes ☐ No	

Medical Insurance
ARKids #
Does child have any special dietary needs? ☐ Yes ☐ No
List any allergies (food, insects, etc.):

Has child attended a state-funded Pre-K (ABC) program? ☐ Yes ☐ No
If so, where?
Will child be concurrently enrolled in an ABC center and HIPPY or PAT program? ☐ Yes ☐ No
If so, which HIPPY or PAT Program?
Does child receive any special education services? ☐ Yes ☐ No

Child's Name	List any medical or developmental disabilities	Name of School Readiness Participant selected	List days and hours of care needed for the child	Child attends ABC or Head Start	School child currently attends
				☐ Yes ☐ No	

Medical Insurance
ARKids #
Does child have any special dietary needs? ☐ Yes ☐ No
List any allergies (food, insects, etc.):

Has child attended a state-funded Pre-K (ABC) program? ☐ Yes ☐ No
If so, where?
Will child be concurrently enrolled in an ABC center and HIPPY or PAT program? ☐ Yes ☐ No
If so, which HIPPY or PAT Program?
Does child receive any special education services? ☐ Yes ☐ No

Emergency Contact if parent/guardian cannot be reached:

Name:	Relationship:	Phone:	
Address:	City:	State:	Zip:
Physician Name:		Phone:	
Address:	City:	State:	Zip:

Consent for Emergency Medical Care:

I _____ (Parent/Guardian's Name) _____ (Relationship) of _____ (Child Name)

Do hereby request and give consent to the Director/Caregiver of the School Readiness 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 parents 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.

– _____ (Parent/Guardian Signature) – _____ (Date)

Authorized Representative (If applicable): If you want to choose someone to represent you, please complete the following information. If you name an authorized representative, this person will be able to talk to the case manager on your behalf. (Photo ID required for authorized representative)
CCDF Program Participant (School Readiness provider) CANNOT be listed as authorized representative

Name of Authorized Representative:	Home or Cell Phone #

***Applicant Certification:**

I certify under penalty of perjury and fraud that all information I have supplied is true and correct. I understand that giving false information or withholding information may result in denial, termination, or disqualification of services or criminal prosecution, and the repayment of financial assistance made on my behalf. I authorize OEC to collect information from other sources to determine my eligibility for services. I authorize any source OEC deems necessary to determine eligibility to release information concerning me. I certify that I have read and understand my Rights and Responsibilities, (available on the website).

Applicant Signature: _____ **Applicant Printed Name:** _____ **Date:** _____

Teen Parent Signature: _____ **Teen Parent Printed Name:** _____ **Date:** _____

Official use only:
Program applying for? ☐Low Income ☐ESS ☐ABC ☐EHS ☐Federal Pre-K ☐ABC/ITS ☐ABC Summer ☐Other

Beebe Public Schools
Student Health History

Student Name: _____

Grade: _____ DOB: _____ Age: _____ Sex: _____

Primary Contact: _____

Relationship: _____ Phone: _____

If parents or the emergency contact listed cannot be reached, does the school have the parents' consent to take the child to a doctor or hospital for treatment? It is understood that the parent is responsible for all medical expenses involved.

Please Circle One: Yes No

Physician_____ Phone: _____

Preferred Hospital_____

Does your child have a medical condition of which we should be aware? Yes No

Please Check all that apply: _____Asthma _____ADHD _____Diabetes _____Seizures

If others, please explain:

_____

List other condition(s):

_____

List all current medications:

_____

_____

Will medication be required during school hours? (Circle One)Yes No

(*If yes, please complete medication request form available from your school nurse)

Allergies (food & drug): Yes or No

If your child has food allergies that affect what he/she eats in the cafeteria, please have your child's doctor complete the "Certification of Special Dietary Needs." You can pick this form up from the school nurse.

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Written permission must be received from the parent/guardian in order for a child to receive medicine at school. Listed below are over-the-counter medications that our school keeps in stock for administration to students. Licensed school nurses will supervise administration of medications. All medications will be given according to label directions on the container. Indication(s) for the administration of medicine will be determined on an individual basis. This authorization is valid ONLY for the school year indicated on the date below.

- Acetaminophen / Ibuprofen (regular strength) **WILL NOT BE GIVEN BEFORE 10:00am OR AFTER 2:00pm** *may be given for fever over 102 degrees, and headaches and/or other pains not relieved by other means such as ice, heat, food, rest, etc.
- Antacid
- Cough Drops
- Benadryl – given in case of allergic reaction (indication for administration to be determined by the school nurse)
- Over The Counter Medications (ex: oral pain reliever, eye drops, topical ointment/cream/spray, throat spray, etc.)

_____ _____

Parent/Guardian Signature Date

updated 3/2022

PARENTS, please complete this form

ARKANSAS BETTER CHANCE PROGRAM WELL CHILD SCREENING (EPSDT) FORM

To Parent or Guardian:
In order to provide the best learning experience for your child, the 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 section "Part-I" of the form, sign it and give to your child's physician or licensed nurse practitioner. Once the 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

☐ AR Kids A ☐ Private Insurance
☐ AR Kids B ☐ 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.	☐	☐	Do you have any concerns about your child's general health?
2.	☐	☐	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	☐	☐	Does your child have any allergies (like to food, medicine, dust)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury?
7.	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	☐	☐	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	☐	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☐	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 _____

HAVE DOCTOR COMPLETE (OR SUBMIT A COPY OF A RECENT WELL-CHILD CHECKUP)

ABC Application 2022-2023

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:
This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight	Height	BMI	Temp	Blood Pressure
lb. %ile	in. %ile	%		/

History Update
D Yes D No Any changes in patient health since last visit? Explain:
D Yes D No Any family history of heart disease for anyone under 55 years of age?
D Yes D No Any family history of abnormal cholesterol?

Health
D Good appetite
D Drinks lowfat milk
D Encourage diet of fruit and vegetables
D Limits fast food
D Picky or variable eater
D Brushes teeth, sees dentist

Social and Behavioral
D Parents discipline appropriately
D Dresses self, helps at home
D TV and video games are limited
D Praised for good behavior
D Has friends and playmates

PHYSICAL EXAM

	Norm	Abnormal
General	D	D
Head	D	D
Neck	D	D
Eyes	D	D
Ears	D	D
Nose	D	D
Throat	D	D
Mouth	D	D
Teeth	D	D
Lungs	D	D
Heart	D	D
Femoral Pulses	D	D
Genitals	D	D
Extremities	D	D
Gait	D	D
Spine	D	D
Skin	D	D
Neuro	D	D

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L R		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

Immunizations
D Yes D No All immunizations are current.
D Yes D No Child has had all immunizations possible at this time.
Child needs: D DTaP D IPV D HepB D HiB D MMR D Varivax D PCV-7 at_____years/_____months

Referrals
D Follow up visit needed in _____ weeks / months
D Return check at_____years_____months
D Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions
D Well child, normal growth and development
D _____

_____, MD / DO / NP Date_____

CLINIC INFORMATION (or stamp)

Name_____
Address_____
City_____
Zip Code_____ Phone_____

Wilbur D. Mills Education Service Cooperative
Early Childhood Special Education
P.O. Box 850 Beebe, AR 72012
Phone: (501) 882-3852 fax: (501) 882-8602

Parent Consent for Screening
2026-2027

Name of child: _____ ___Male ___Female

Date of Birth: _____ Age: _____ SSN: _____

Race: (check all that apply) Check if Interpreter is needed ____Child ____Parent
___Hispanic ___Amer. Indian/Alaskan ___Asian ___Hawaiian ___African American ___Caucasian

Does child have Medicaid/ArKids: ___YES ___NO ArKids ID number: _____

School district of child's primary residence: _____

Does child attend preschool/daycare? ___YES ___NO If yes, where: _____

Is child currently receiving or has received any of the following: (attach a copy of latest evals)
___Speech ___Occupational therapy ___Physical therapy ___Counseling ___HIPPY

Name of parent/guardian(s): _____

Parent/guardian email address: _____

Physical address: _____
Street name City Zip code

Mailing address: _____
Street name City Zip code

Contact Number: _____/_____
___cell ___home ___work ___cell ___home ___work

I give Wilbur D. Mills Education Service Cooperative permission to screen my child

_____ _____
Parent/guardian signature Date

Location: _____

Consent to Access Public Insurance
Hearing and Vision Screening

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid. In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies. Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

As part of our screening process, Wilbur D Mills screens each child's hearing and vision. Please indicate below if you give your consent for Wilbur D Mills Educational Service Cooperative to bill Medicaid for the vision and hearing screening provided to your student.

____ **I do give permission for the school district to bill Medicaid**

____ **I do NOT give permission for the school district to bill Medicaid**

_____ _____

Student Name **Service Location**

_____

Parent/Guardian Printed Name

_____ _____

Parent/Guardian Signature **Date**

WDMESC EARLY CHILDHOOD SPECIAL EDUCATION **Child's Name:**_____

Directions: Place an X in the box that best describes how your child can do each task.

GRAY BOXES FOR WDMESC USE ONLY

A young child's behavior is not the same from day to day. Think of your child's average ability at home, not his or her very best or worst day. Mark each item by putting an X in 1 of the boxes

Part 1 Self Help Development Task	Most of the time	Sometimes if I help	Rarely or Never	Not allowed to or not asked
1) Buttons clothing without help				
2) Puts toys or books away when asked				
3) Spills food or drink when eating				
4) Unscrews bottle caps without help				
5) Wets or soils pants				
6) Washes and dries hands when needed				
7) Puts clothes/shoes where they belong when asked				
8) Brushes teeth without help				
9) Blows and wipes nose without being asked				
10) Puts clothes on backwards				
11) Puts each shoe on correct foot				
12) Gets dressed without help				
13) Wets bed				
14) Picks up after self without being asked				
15) Brushes or combs hair without being asked				
16) Washes self during bath or shower				
17) Pours from a small can or carton without spilling				
18) Uses a fork,spoon,or chopsticks correctly				
19) Pours dry cereal/milk into bowl without spilling				
20) Uses the toilet without help				
21) Wakes up and needs help going back to sleep				
22)Follows safety rules (stays away from hot oven,etc)				

Child's Name

Part 2 - Social Emotional Development Feeling & Behavior	Always or almost always	Sometimes or partially	Rarely or never
1) Smiles or laughs when something is funny			
2) Argues when denied own way			
3) Breaks toys or other objects on purpose			
4) Plays well with other children			
5) Has tantrums (stomps feet, screams, etc)			
6) Solves problems by talking rather than hitting,pushing or biting			
7) Acts without thinking (runs into street without looking both ways, etc)			
8) Admits when he or she makes a mistake			
9) Stays calm when things do not go as planned			
10) Blames others when bad things happen			
11) Knows when people are happy or sad			
12) Interrupts (talks when others are speaking)			
13) Goes to bed easily			
14) Asks before using other people's things			
15) Works well with others			
16) Shows pride in doing something well			
17) Bangs head on the floor, wall, or bed			
18) Clings or hangs onto you			
19) Whines or pouts			
20) Seems afraid of many things			
21)Shows concern for someone who is crying			
22) Hurts others (hits, bites, kicks, punches, etc)			
23) Gives up easily			
24) Makes transitions easily (moves easily from one transition to the next)			
25) Falls and hurts self			
26) Is restless and can't sit still			
27) Wanders away from you in public places			
28) Acts very sad or withdrawn			