



## NC Pre-K Program Child Application for 2026-2027

### 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 2025 income tax return (1040); OR W2 forms for 2025; 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 2025 income tax return (1040). If taxes are not available, contact NC Pre-K Coordinator at [ncprek@rapc.org](mailto:ncprek@rapc.org) for assistance.
  - c) Documentation of Per Capita/Indian Gaming Proceeds from 2025: check stubs **OR** 1099 Miscellaneous tax form bearing name of recipient; **OR** first 2 pages of 2025 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 2025 income tax return (1040);
  - f) Workman's Compensation (attach copy of award letter) **OR** first 2 pages of 2025 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 required.

Contact the Region A Partnership for Children at

[www.rapc.org](http://www.rapc.org)

116 Jackson Street, Sylva, NC 28779

Phone 828-586-0661, ext. 1040

[ncprek@rapc.org](mailto: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

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

Is This Person Employed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Regular wages/employment income?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seeking Employment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Per Capita/Indian Gaming Proceeds?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disabled?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alimony Payments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retired?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Unemployment Benefits?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In High School/GED Program	Yes <input type="checkbox"/> No <input type="checkbox"/>	Workman's Compensation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In College?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Child Support for any minor children living in same home?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Retirement income?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Disability Income?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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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# NC Pre-K Program Child Application for 2026-2027

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**

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

Is This Person Employed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Regular wages/employment income?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seeking Employment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Per Capita/Indian Gaming Proceeds?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disabled?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alimony Payments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retired?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Unemployment Benefits?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In High School/GED Program	Yes <input type="checkbox"/> No <input type="checkbox"/>	Workman's Compensation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In College?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Child Support for any minor children living in same home?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Retirement income?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Disability Income?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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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## NC Pre-K Program Child Application for 2026-2027

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](mailto:ncprek@rapc.org) anytime! Check out our website at [www.rapc.org](http://www.rapc.org)!

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Region A Partnership for Children  
NC Pre-K Program Eligibility Info Sheet  
2026-2027 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: \_\_\_\_\_

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## 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: \_\_\_\_\_