



Families and Children Together, Inc.

Pregnant Mom Application



APPLICATIONS WILL NOT BE ACCEPTED WITHOUT COPIES OF THE FOLLOWING DOCUMENTATION

1. **Household income verification for the past twelve months.** Household income includes all means of support for the last twelve months from all parents/guardians of the unborn baby who also live in the same household as the child. **One month of check stubs, tax returns, W-2s, employer statements, TEA, SSI, WIC, SNAP, Unemployment, etc.**

Please provide a copy of your Medicaid card, AR Kids card, or Private Insurance card if you have one. Medicaid applications are available upon request.

Should you have any questions regarding the required information, please contact the ERSEA Coordinator at (870) 862-4545 or your local center.

Please indicate below where you would like to be placed.

Home Based Options:

- Calhoun County
- Columbia County
- Dallas County
- Ouachita County
- Union County

Is there a child under the age of 5 in your household? Yes No

If yes, please ask for an Early Head Start/ Head Start/ Arkansas Better Chance application.

FACT, Inc. is an equal opportunity provider and employer.



F.A.C.T., Inc. takes many factors into consideration in order to determine eligibility. In addition to your income level and the age of your child, other child and family needs are noted. The following information will be used to help determine eligibility and for us to become familiar with your family. Applications are evaluated on a points system and those with the highest points are selected first.

Please Print Clearly

Mother's Information

E-mail address: _____

First Middle Last Date of Birth

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> Master's	<input type="checkbox"/> HS Graduate	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & School	<input type="checkbox"/> Biological/Adopt/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> GED	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & School	<input type="checkbox"/> Foster	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Grandchild		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Some College	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Other Relative		
<input type="checkbox"/> Training Cert	<input type="checkbox"/> Grade 9/less					

Is parent attending school? WHERE: _____
of hours/semester: _____

Primary Health Coverage	Medicaid # / Insurance #
<input type="checkbox"/> AR Kids <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None	# _____

How did you hear about us? agency employee child previously enrolled family/friend internet/website radio
 newspaper referred by another agency sibling attended walk-in word of mouth

Is this your first time applying for the Pregnant Mom program? Yes No

Who will be legally responsible for the child? Both Parents Mother Father Other
Name: _____

Father's Information - Only if in Household

E-mail address: _____

First Middle Last Jr., Sr., II, III Date of Birth

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient
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<input type="checkbox"/> Some College	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Other Relative		
<input type="checkbox"/> Training Cert	<input type="checkbox"/> Grade 9/less					

Is parent attending school? WHERE: _____
of hours/semester: _____

List each person living in the home.

Name (First, Last)	Date of Birth	Relationship to Child

Family Information

Living Address	Address Line 2	Zip	City	State	County
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Mailing Address (if different)	Address Line 2	Zip	City	State	County
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Phone Numbers	Name of Contact	Type (check one)
_____	Mother:: _____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
_____	_____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
_____	_____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

Parental Status (check one)	Primary Language at Home	Homeless Family	Military Active Duty	Military Veteran	Referred by Child Welfare Agency
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYMENT INFORMATION: List employment history for the last twelve months for both parent(s) and/or all guardian(s) of the unborn baby. You must list ALL places of employment and proof of income must be provided for each.

Parent Name	Employer	Work Address	Work Phone Number	Beginning Date	Ending Date

OTHER INCOME/PUBLIC ASSISTANCE:

If a household member receives, or has received any of the following during the last twelve months: Proof must be provided with this application. Please check all boxes that apply.

- SNAP (food stamps)
- Supplemental Security Income (SSI)
- TANF (TEA, Work Pays, Career Pathways)
- Unemployment Benefits, Date Began Drawing: _____
- WIC Household ID # _____

MEDICAL/DISABILITY/SPECIAL NEEDS:

Do you have any pregnancy related health concerns that are being treated at this time? Yes No
If yes, please describe: _____

Please describe any other special needs or concerns regarding your health: _____

Expected Delivery Date: _____ Expecting: Single Twins Triplets Other

Trimester: 1st 2nd 3rd

Are you currently enrolled in the Hannah Pregnancy Resource Center? Yes No

ADDITIONAL FAMILY INFORMATION: Does your family have any special circumstances, concerns or needs? Such as:

- Abusive home situation alcohol, drugs, child or spousal abuse
- Applicant is a foster child
- Child's parent is currently incarcerated (in prison/jail)
- Current address is a temporary living arrangement due to loss of housing or economic hardship. ***Fill out a Residency Questionnaire***
- First time parent
- Parent/guardian has no work experience or formal education (such as parenting classes, workshops or college courses) in childcare
- Parent/guardian is unemployed due to loss of job or being unable to work
- Recent death in family within last 12 months
- Other Please explain: _____
- None

Do you have a child currently attending: Head Start ABC Other Preschool Program?

If yes, where? _____

Are you related to a staff member of F.A.C.T., Inc.? If so, please state who and what the relationship is: _____

****This information will only be used for placement if you are selected for enrollment.**

I certify that the above information is true. I understand that if any information is found to be false, my family's participation in this Agency's programs may be terminated, and that I may be subject to legal action. I also understand that this information is confidential and is accessible to me during normal business hours.

Signature of Parent/Legal Guardian

Printed Name of Parent/Legal Guardian

Date

Applications cannot be processed until a review of the information and documentation with the parent/guardian is completed. Please call your nearest center to make an appointment for this review. *If you cannot reach anyone at your nearest center during the summer months, please call the central office at (870) 862-4545.

Bearden HS, EHS 870-687-2955
 Bearden ABC 870-687-2020
 Bradley HS 870-894-6153
 Camden HS, EHS, ABC 870-836-5227
 Emerson HS 870-696-6001
 Fairview-El Dorado HS, EHS 870-864-0117
 Fordyce HS, EHS 870-352-3333

Hampton HS, EHS 870-798-3004
 Hope HS 870-777-8540
 Junction City HS, EHS, ABC 870-924-5615
 McNeil HS 870-739-9920
 Magnolia East HS, ABC 870-626-5026
 Magnolia EHS 870-234-3447

Morning Star HS, EHS 870-862-2755
 Nevada HS 870-871-1334
 Strong HS,EHS, ABC 870-797-3015
 Taylor ABC 870-694-6018
 West Woods HS, EHS, ABC 870-875-1714

Staff Use Only

I have conducted either an in-person or telephone interview with the family regarding their application and eligibility. I certify that I have examined this application and that it is complete with all necessary documentation attached.

Signature of Staff Person Submitting: _____ Date _____

Staff Comments: (to include any special notes on a family's circumstances; reason for telephone interview if person is not possible.)

Application left in community at: _____

By (staff person): _____