ABCSS Application for 2026-2027 School Year

The Arkansas Better Chance Program services children who meet the following criteria:

- ❖ Gross Family income may not exceed 200% of the Federal Poverty Level.
- ❖ The child resides within the boundaries of an Arkansas School District and the program has space for the child to attend.

Family Size	Income guideline: 200% Federal Poverty Level
1	$31,920
2	$43,280
3	$54,600
4	$66,000
5	$77,360
6	$88,720
7	$100,080
8	$111,440

For families/households with more than 8 persons, add $11,360 for each additional person.

A completed application and all documents must be returned before the child will be enrolled.

- ❖ **Proof of Income(30 days consecutive check stubs, W-2, Income verification form)**
- ❖ **Current Physical(Vision and Hearing are required)**
- ❖ **Current Dental Exam**
- ❖ **Birth Certificate, Social Security Card, Insurance Card**
- ❖ **Parent/Guardian Photo ID**

Arkansas Better Chance for School Success

Child Application:

Name(First,Middle,Last)_____

Male:___Female:__Date of Birth:___/___/___S.S.N:_____/_____/_____

Primary Language:_____ Second Language:_____

Ethnicity:_____ Race:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:_____ School District:_____

Who does the child live with?_____

Has the child attended a state funded Pre-k program(ABC)?_____

If so Where?_____

Will this child be concurrently enrolled in an ABC Center and HIPPY or PAT Program?_____. If so where?_____

Does this child currently receive any Special Education Services (Speech, OT, DT, PT)?_____

Additional Information:
(Circle any that apply)

Does the enrolling child fall into any of the categories below? YES NO

- A Foster Child
- A child with an incarcerated Parent
- In custody of living with a family member other than the mother or father (with immediate family member arrested for or convicted of drug related offenses. With a parent activated for overseas military duty?

Arkansas Better Chance for School Success

Primary Caregiver Application:

Name(First,Middle,Last)_____ Male:____
Female:____ Active Service Member:____
Email Address:_____ Home/Cell
Phone:_____Address:_____ City:_____
State:_____ County:_____ Zip:_____ DOB:____/___/____ S.S.
Number:____/____/____
Primary Language:_____ Secondary:_____
Ethnicity:_____ Race:_____ Education Level:_____
Marital Status:_____ Employment Status:_____
Annual Income:$_____ Employer Name:_____
Employer Address:_____ Phone number:_____

Secondary Caregiver Information:

(2nd Parent/guardian in the household with the child will be used for determining eligibility)

Name(First,Middle,Last)_____
Male:____ Female:____ Active Service Member:____
Email Address:_____ Home Phone:_____
Work Phone:_____ Address:_____
City:_____ State:_____ County:_____ Zip:_____
DOB:____/____/____ S.S. Number:____/____/____
Primary Language:_____ Secondary:_____
Ethnicity:_____ Race:_____
Education Level:_____ Marital Status:_____
Employment Status:_____ Annual Income:$_____
Employer Name:_____
Employer Address:_____ Phone number:_____

Arkansas Better Chance for School Success

Household Information

Name:	Relationship:

Emergency Contacts:

Name:_____ Phone:_____ Adress:_____

Name:_____ Phone:_____ Adress:_____

Name:_____ Phone:_____ Adress:_____

Name:_____ Phone:_____ Adress:_____

Arkansas Better Chance for School Success

Last Name:	**First Name:**	**Middle:**
As specified by Social Services, the ABC Program is required to have written authorization concerning emergency medical care in case parent(s) cannot be contacted. I give permission to the teachers and HSCC Staff to obtain emergency medical care in the event I, my spouse, alternate contact(s) cannot be located immediately.		
Behavior Policy: discipline shall reflect positive guidance, be consistent, and individualized for each child. Such discipline shall be appropriate to the child's level of understanding and directed toward teaching acceptable behavior and self-regulation. Corporal punishment is an unacceptable method of discipline for children in ABC funded programs and shall not be used.		
Sunscreen and Weather: Children shall be protected from overexposure to the sun. Sunscreen shall be used if needed and as directed by the parent. Children will play outside daily except for in an even of severe weather. I give permission for my child to receive sunscreen. I have received guidelines for outside play. **Shaken Baby Syndrome**: I have been given information on Shaken Baby Syndrome.		
Allergy: If your child has a specific allergy(food, medicine, insect sting, etc.) we will need to have a note from your child's pediatrician stating that he/she requires special consideration. Please provide documentation concerning allergies before the start of school. **My child has the following allergies**:_____		
Kindergarten Readiness: I have received a copy of the Arkansas Kindergarten Readiness Skills.		
Calendar: I have received a link for the Getting Ready for Kindergarten Calendar. http://humanservices.arkansas.gov/dccece/classroom_docs/DHS_ricalendar		
Field Trips: Hot Springs Childcare Center has permission to transport my child by Van to and from any planned field trips.		
Health Insurance and Medical Home: My child has _____ insurance. I have received a copy of an Arkids First Application and your medical home Brochure.		
HIPPA Release form/Allergy and Medical Postings: I _____ parent or guardian of _____ authorize HSCC to post my child's allergy/medical alert in his/her classroom, kitchen, and other areas as needed. I understand that this information will be posted to insure all staff members are aware of my child's allergy/medical needs. **Parent/Guardian Signature:**_____ **Date:**_____		
Childcare Licensing Visits: Childcare Licensing evaluates Centers throughout the year. Visits are unannounced and a compliance form is completed during each visit. These forms are available upon request.		
I, the undersigned, have read the previous statements regarding policies and requirements and I am in agreement. I acknowledge that by signing I am giving my consent to the above. **Parent/Guardian Name:**_____ **Date:**_____		

Arkansas Better Chance for School Success

Suspected Child Abuse Policy:

As required by law, any suspected cases of child abuse/neglect(physical, emotional, or sexual) will be reported to the proper authorities.

1. Immediately notify the childcare director
2. Complete written report
3. Make and observation of the child and complete further reports as needed
4. Call the Child Abuse Hotline: 1-800-482-5964

I understand the Child Abuse policy of Hot Springs Child Care Center.

Parent/Guardian Signature:_____ Date:_____

Financial Agreement for Aftercare:

I understand that the ABC Program hours are 7:30a.m.-3:00p.m. I understand that HSCC after care hours are 3:00p.m.-5:30p.m. I understand that there is a fee of $16.00 per day for the aftercare program. I understand that it is to be paid in advance. I understand that if my child is at HSCC after 3:00p.m. it is my responsibility to pay the $16.00.

Parent/Guardian Signature:_____ Date:_____

Photo Release:

Please circle your preference:

I authorize Hot Springs Childcare Center to photograph my child. I understand photos may be used on social media and publicity purposes.

Parent/Guardian Signature:_____ Date:_____

Sex Offender Policy:

It is Hot Springs Child Care Center policy that no persons listed on the sex offender registry shall be permitted on the premises. By signing, you acknowledge that you have been made aware of this policy and acknowledge that there is no one on the registry that will be on HSCC premises in connection with you or your child.

Parent/Guardian Signature:_____ Date:_____

Child Name:_____

I have received a QR Code and/or Copy of the 26-27 Parent Handbook

Parent Name:_____ Parent Signature:_____

Date:____ /____ /____

Arkansas Better Chance for School Success

Diet Prescription for Meals at School: Student's Name: _____ Teacher:_____
Medical Food Restrictions (to be completed by a physician or medical personnel): Please list disability or medical condition that requires the child to have a special diet._____
Please list restrictions/substitutions below: Please attach a copy of the child's diagnosis with this form.
Physician/Recognized Medical Authority Signature:_____ Date:_____
Parent/Guardian Signature:_____ Date:_____

Arkansas Better Chance for School Success

Health Policy
No child or staff shall be Admitted who has a Contagious or Infectious Disease

Parents/Guardians shall be notified to pick up the child who exhibits any of the symptoms below.

1. Fever: A body temperature of 101 or greater in a 24-hour period. Child may not return to school until they are 24 hours fever free without fever reducing medication.
2. Diarrhea: Two (2) or more water stools in a 24-hour period. Child may not return until they are diarrhea free for 24-hour period.
3. Vomiting: Vomiting on two or more occasions withing the past 24-hour period. Child may not return to school until they have been 24 hours without vomiting.
4. Rash: Body rashes, not obviously associated with diapering, heat, or allergic reactions to medication.
5. Sore Throat: If associated with fever or swollen glands in the neck.
6. Severe Coughing: Episodes of coughing that may lead to repeated gagging, vomiting, or difficulty breathing.
7. Pink Eye: Pin or red eye(s) which may be swollen with white or yellow discharge. The child must be on antibiotics for 24 hours before returning.
8. Untreated Scabies, Headlice, or the presence of Nits. May return after treatment.
9. Multiple Sores: Inside the mouth with drooling: Unless a health care provider determines the condition is noninfectious.
10. Round Worm: A fungal infection of the scalp or skin; may return after evaluation or under treatment by a health care provider.
11. Impetigo: May return 24 hours after treatment is initiated.

Any child who becomes ill and unable to participate in daily activities shall be separated from the other children, the parent shall be called to pick that child up.
Parents/Guardians of all children shall be informed of contagious illnesses as soon as possible.
I have read the health policy of the ABC Program and understand that I am responsible for following the guidelines and for notifying my child's school of any contagious illness my child might have.

Parent/Guardian Signature:_____ Date:_____

Arkansas Better Chance for School Success

Authorization for the Release of Records:

To whom it may concern:

I do hereby give my permission for (name of business) _____

Address:_____ City:_____ State:_____ Zip:_____

To release the following information concerning my child to:

Hot Springs Childcare Center

I authorize the release of any medical information necessary to meet this request. Such release may include information concerning communicable diseases such as hepatitis, syphilis, gonorrhea, and the human immunoaffinity virus, also known as acquired immune deficiency syndrome.

Parent/Guardian Signature:_____ Date:_____

Identifying Information:

Child's Name:_____ DOB:___/___/___ SSN:____/____/____

Most recent physical/well child exam date:___/___/___

Most recent dental exam:___/___/___

Information Needed:

Hematocrit_____ Dental Screening:_____ Copy of Insurance:_____

Physical:_____ Immunization Record:_____ Lead:_____

Developmental Screening:_____ Other:_____

HSCC I, II, III
Screening Date:_____
600 Main Street, Unit L
Hot Springs, AR, 71913
Phone: 501-232-7552
Email: swpt@swpediatrictherapy.com
Fax: 501 - 421-3186

South West Pediatric Therapy
In Association With
Hot Springs Child Care Center Inc.

Free Developmental Screenings

Dear parents,

South West Pediatric Therapy provides screenings for Hot Springs Childcare Centers every 12 months, or as needed. The screenings are a brief assessment to determine if a child is developing age appropriately in the areas of fine motor, visual perception, visual motor, sensory processing, gross motor, speech articulation and receptive/ expressive language skills. South West Pediatric Therapy provides this service at no cost to HSCC or parents. If your child exhibits concerns during the screening, you will be contacted by the screening consultant.
In association with HSCC, we thank you for allowing South West Pediatric Therapy to provide the best quality care for your child. Please call South West Pediatric Therapy directly with any questions regarding the screenings.

Child's Name:_____Date of Birth:_____
If your child was premature and is younger than 2 please indicate the weeks of gestation _____

Classroom/Teacher:_____

Parent's Name:_____Phone Number:_____

Address: _____

Parent's concerns:_____

Teacher's concerns:_____

Note: If your child is receiving therapy services from another provider, it may not be appropriate for him/her to participate in this screening. Please indicate on this form if your child is already receiving services with another provider. Results of this screening may be shared with your child's teacher and/ or staff of HSCC.

By signing below, I consent to allow my child to participate in developmental screenings with South Pediatric Therapy:

Parent/Legal Guardian Signature:_____Date:_____

Children who are in need of Occupational or Speech Therapy services can receive services from a South West Pediatric Therapist licensed therapist at Hot Springs Childcare Centers.

Please return this screening consent form to the office at your child's daycare.

DAWSON EDUCATION SERVICE COOPERATIVE OFFERS *FREE* DEVELOPMENTAL SCREENINGS

(Ages 3 through 5)

Speech *Vision *Hearing * General Development

Children whose skills are delayed may be eligible for ***free*** Early Childhood Special Education Services

For more information or to schedule a screening appointment call now!

1-870-246-7928

Dawson Early Childhood Special Education Office is open year round and serves 21 surrounding school districts.

"Serving the Schools ----- Serving the Children"

Dawson Education Service Cooperative
Early Childhood Special Education Department
711 Clinton Street, Suite 201
Arkadelphia, AR 71923
Office (870) 246-7928 Fax (870) 246-3130

Screening Consent Form

Child's Name: (Full Legal Name)_____
First Middle Last (Nickname)

Child's Social Security Number (REQUIRED): ____-____-____ **School District** _____

Does your child receive Medicaid/ARKids? Yes ☐ No ☐ If yes, Medicaid Number _____

Date of Birth _____ Age _____ Sex: Male ☐ Female ☐

Race: (check all that apply): African American (Black) ☐ White ☐ Asian ☐ Hispanic ☐

American Indian/Native American ☐ Native Hawaiian/Pacific Islander ☐

County of Parent Residence: _____

Parent or Legal Guardian Name: _____
First Last

Address:_____ City: _____ State:_____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone_____

Day Time Phone # _____ e-mail address:_____

Child's Primary Care Physician: _____ Clinic _____ Phone _____

Child attends (please circle one): Day Care / Head Start / Preschool / Mother's Day Out / Home Based

Center Information: _____
Name Address City Zip Phone

Name of Classroom Teacher _____

Has your child had any previous evaluations: Yes ☐ No ☐ Has your child received therapy: Yes ☐ No ☐

If yes to either of the above questions, please explain: _____

Are their any behavioral issues? If so, please explain: _____

Will an interpreter be needed? Yes ☐ No ☐ Language_____ or Hearing impaired: Yes ☐ No ☐
(specify lang.)

I give permission to have my child screened by Dawson Education Service Cooperative Special Services Program. The screening may include one or more of the following areas: speech, development, motor, vision and/or hearing. If you have any questions you may call 870-246-7928

Parent Signature for consent to screen: _____ Date: _____

For office use only: RCVD by _____ on ____/____/____

Revised August 2017

Parent/
Teacher Report and Scoring Form—Self-help and Social-Emotional Scales

A. Child's Name _____ Date of Screening _____ (Year) _____ (Month) _____ (Day) School/Program _____

Parent(s)/Caregiver(s) _____ Birth Date _____ Teacher _____

Age _____ Examiner _____

Directions: Read each item and circle the response or description that best reflects the child's skill level.

SELF-HELP SKILLS

A. Eating Skills

1.	Does _____ use a spoon? If yes, does _____ place the spoon in his/her mouth without turning the spoon upside down, with little or no spilling of food?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1
2.	Does _____ use the side of the fork for cutting soft food, such as a piece of baked potato or a piece of cake?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1
3.	Does _____ hold a fork in his/her fingers, not in his/her fist?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1

Total for A. Eating Skills ___ /3

B. Dressing Skills

4.	Does _____ put on his/her shoes? **Criteria:** Buckling, tying, or Velcro® fastening is not required for credit.	No = 0	Yes (sometimes on wrong feet) = 1	Yes (each shoe on correct foot 90% of the time) = 2 / 2
5.	Does _____ dress himself/herself unsupervised?	Rarely/No = 0	Sometimes = 0	Most of the time, except for help with difficult fasteners = 1
		Yes (completely dresses himself/herself, putting all clothes on correctly and fastening all fasteners) = 2	Yes (completely dresses himself/herself, including tying shoelaces and fastening all fasteners) = 3 / 3	
6.	Does _____ put on his/her socks?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1

Total for B. Dressing Skills ___ /6

C. Toileting Skills

7.	Does _____ get on the toilet or potty by himself/herself (even if he/she needs help with clothing)?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1
8.	Does _____ have bowel movements ("poop") in the toilet or potty (no more than one accident a week)?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1
9.	Does _____ urinate ("pee") in the toilet or potty (no more than one accident a week)?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1
10.	Does _____ attempt to wipe himself/herself after toileting?	Rarely/No = 0	Sometimes = 0	Most of the time = 1
	OR (Answer only the more appropriate of these two questions.) Does _____ wipe himself/herself independently after toileting?	Rarely/No = 0	Sometimes = 0	Most of the time = 2 / 2
11.	Does _____ take care of his/her toileting needs?	Rarely/No = 0	Sometimes = 0	Yes (flushing the toilet most of the time after using it) = 1 / Yes (flushing the toilet and washing and drying his/her hands most of the time) = 2 / 2
12.	Does _____ go to the bathroom on his/her own without being asked or reminded?	Rarely/No = 0	Sometimes = 0	Most of the time = 1 / 1

Total for C. Toileting Skills ___ / 8

TOTAL FOR SELF-HELP
(A. Eating Skills, B. Dressing Skills, C. Toileting Skills) ___ / 17

Self-help and Social-Emotional Scales *(continued)*

SOCIAL AND EMOTIONAL SKILLS

D. Relationships with Adults

13.	Does _____ respond with feelings of pride and enthusiasm when he/she earns positive feedback?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
14.	Does _____ look forward to sharing his/her feelings with you when he/she is happy?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
15.	Does _____ enjoy sharing information with you about himself/herself, such as things he/she likes, names of his/her family members or pets, or what he/she did over the weekend?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
16.	Does _____ share his/her thoughts and ideas with you?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for D. Relationships with Adults ___ / 4

E. Play and Relationships with Peers

17.	Does _____ have several friends but one who is a special or best friend?		
	No = 0	Yes = 1	___/1
18.	Does _____ have a best friend with whom he/she is close and who reciprocates by coming over for play dates or extending an invitation to a party?		
	No = 0	Yes = 1	___/1
19.	Does _____ play cooperatively in a large-group game, such as duck-duck-goose, tag, or kickball?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1 ___/1
20.	Does _____ give verbal directions or incorporate verbal directions into play activities?		
	Rarely/No = 0	Sometimes = 0	Most of the time = 1 ___/1

Total for E. Play and Relationships with Peers ___ / 4

F. Motivation and Self-Confidence

21.	Does _____ maintain interest when engaged in a small-group activity or project?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
22.	Does _____ show that he/she likes to finish what he/she starts, perhaps by dawdling less than at an earlier age?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
23.	Does _____ approach new tasks with confidence and a "can-do" attitude?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
24.	Does _____ remain focused on what he/she has been asked to do even when there are minor distractions, such as a car making noise outside or someone tapping a pencil?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for F. Motivation and Self-Confidence ___ / 4

G. Prosocial Skills and Behaviors

25.	If supervised by an adult, does _____ take turns without undue objection?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
26.	Does _____ understand or accept the need to share and take turns, perhaps willingly taking turns even if he/she isn't asked to?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
27.	Does _____ ask an adult for permission before using things that belong to others or before engaging in an activity that may be restricted, such as going to the bathroom or leaving the classroom?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1
28.	Does _____ react to a disappointment or failure in an acceptable manner by being a good sport and refraining from shouting or getting upset?			
	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for G. Prosocial Skills and Behaviors ___ / 4

TOTAL FOR SOCIAL-EMOTIONAL
(D. Relationships with Adults, E. Play and Relationships with Peers, F. Motivation and Self-Confidence, and G. Prosocial Skills and Behaviors) ___ / 16

Childs Name: _____

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

SELECTIONS:

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. _____
PHYSICIAN NAME

2. _____
PHYSICIAN NAME

3. _____
PHYSICIAN NAME

CHANGES:

I want to change my primary care physician because:

_____

_____

_____

_____

_____

_____

_____

_____
BENEFICIARY SIGNATURE (Parent/Guardian Signature)

_____
MEDICAID I.D. NUMBER

_____
DATE

DMS-2609 (Rev. 4/07)

ADE-SPED
REQUIRED
FORM
AUG 2017

Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name:_____ **ID:** _____ **Date of Birth:** _____

Age:_____ **Grade:** _____ **Local Education Agency:** _____

Medicaid Number: _____

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, and who receive those services that are identified in their individualized education program (IEP). 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.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.
- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.
- I understand that this may include sharing information with DHS, contracted billing agents, and/or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.
- I understand that information to be released may include: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of service(s), times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child, unless revoked by me.
- I understand that I may revoke consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this form.

_____ _____

Parent or Guardian Signature Date

Is your child covered by private insurance? ☐ No ☐ Yes (If yes, please complete Third Party Liability Section)

Parental Consent to Release Personally Identifiable Information
Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Name: _____ **ID:** _____ **Date of Birth:** _____

Age: _____ **Grade:** _____ **Local Education Agency:** _____

Medicaid Number: _____

Information Related to Billing Third Party Insurance:
Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

☐ I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school.

☐ I give my permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:

Insurance Company: _____

Address: _____

Phone: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Social Security Number: _____

Policy Number: _____ Group Number: _____

_____ _____
Parent or Guardian Signature Date