

0 – 5 YEARS OLD

**MIAMI DADE COUNTY COMMUNITY ACTION AND HUMAN SERVICES DEPARTMENT
HEAD START/EARLY HEAD START
REGISTRATION REQUIREMENTS**

(Parent(s))/Legal Guardian Copy)

The following documentation is needed at the time of the application intake, if applicable. This information is used to determine program eligibility. Provide copies of documents if any of the items checked “yes” on the family circumstances checklist listed on page 3 of the application. Staff is available to assist with the completion of the application. Check documentation provided to staff.

<p>Proof of Age: EHS- Pregnant women. Birth to age 3 years after September 1, 2012. HS- Children must be 3 or 4 years of age on or before September 1, 2012, or no more than five (5) years old after September 1, 2012.</p>	<ul style="list-style-type: none"> • Birth Certificate • Passport • Notarized Affidavit of Age Form • Doctor’s statement (pregnant women)
<p>Proof of parent’s/legal guardian gross income for the past 12 months or the last calendar year (2011).</p>	<ul style="list-style-type: none"> • Signed Income Form Tax 1040 (with eligible child name listed) • W-2 forms • pay stubs • Unemployment Compensation • Written statement from employers • Social Security Supplemental Income (SSI) printout • TANF print out • Child Support • Income Statement
<p>Proof of Parent’s Identification</p>	<ul style="list-style-type: none"> • Driver’s license/Passport • State issued picture I.D. • Employer issued I.D./Military ID • Homeless Shelter ID
<p>Proof of Dade County Residency</p>	<ul style="list-style-type: none"> • Driver’s license • State issued picture I.D. with address listed • Utility Bills (lights, phone, cable, etc) • Lease/Rental and Mortgage Agreement • TANF/SSI/Unemployment Letter
<p>Proof of Disability</p>	<ul style="list-style-type: none"> • Individualized Educational Plan (IEP) • Individualized Family Support Plan IFSP
<p>Proof of Suspected Disability</p>	<ul style="list-style-type: none"> • Doctor/Therapist evaluations and statements outlining concerns
<p>Proof of Homelessness Verification</p>	<ul style="list-style-type: none"> • Statement from homeless facility or social worker • Statement from applicant
<p>Proof of Substance Abuse</p>	<ul style="list-style-type: none"> • Statement from Treatment Program Staff
<p>Proof of Domestic Violence</p>	<ul style="list-style-type: none"> • Statement from Domestic Violence Agency/Staff • Court Documentation (within the last year)
<p>Proof of Student Status</p>	<ul style="list-style-type: none"> • Current Transcript
<p>Proof of Education Eight Grade and Below</p>	<ul style="list-style-type: none"> • Statement from Applicant/Official School Transcript
<p>Proof of Parental Disability</p>	<ul style="list-style-type: none"> • SSI Recipient Letter/Doctor’s Statement
<p>Proof of Pregnancy</p>	<ul style="list-style-type: none"> • Medical Documentation (current)
<p>Proof of Public Housing Residency</p>	<ul style="list-style-type: none"> • MDPHA Rental/Lease Agreement
<p>Proof of Foster Care-Legal Custody</p>	<ul style="list-style-type: none"> • Documentation from Foster Care Agency/Court Award
<p>Proof of Legal Guardianship/Custody</p>	<ul style="list-style-type: none"> • Documentation from the Court System/Court Award

Parents will certify that the information provided on the application and supporting documentation is true and correct and that all parent(s)/legal guardian(s) income are reported. Deliberate misrepresentation of any information submitted may be subject to the child being terminated from the program. An incomplete application and documentation will delay the enrollment process.



Office Use Only
(Checked upon receipt of Documentation)



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Proof of Age : EHS- Birth to age 3 years after September 1, 2012. HS -Children must be 3 or 4 years of age on or before September 1, 2012, or no more than five (5) years old after September 1, 2012)	<ul style="list-style-type: none"> • Birth Certificate • Passport • Notarized Affidavit of Age • Doctor’s statement (pregnant women) 		
Proof of parent’s/legal guardian gross income for the <u>past 12 months or the last calendar year (2011).</u>	<ul style="list-style-type: none"> • Signed Income Form Tax 1040 with eligible child name listed • W-2 forms • pay stubs (proof for the last 12 months) • Unemployment Compensation • Written statements from employers(letterhead) • Social Security Supplemental Income (SSI/TANF) printouts • Child Support Agency • Notarized Income Statement 		
Proof of Parent’s Identification	<ul style="list-style-type: none"> • Driver’s license/Passport/ID from Homeless Shelter • State issued picture I.D. • Employer issued I.D. • Military ID 		
Proof of Dade County Residency	<ul style="list-style-type: none"> • Driver’s license with address listed • State issued picture I.D. with address listed • Utility Bills (lights, phone, cable, etc) • Lease Rental /Mortgage Agreement 		
Proof of Disability	<ul style="list-style-type: none"> • Individualized Educational Plan (IEP) /IFSP 		
Proof of Suspected Disability	<ul style="list-style-type: none"> • Doctor’s Statement outlining concerns 		
Proof of Homelessness	<ul style="list-style-type: none"> • Written Statement from Homeless Facility 		
Proof of Substance Abuse	<ul style="list-style-type: none"> • Written Statement from Treatment Program 		
Proof of Domestic Violence	<ul style="list-style-type: none"> • Written Statement from Domestic Violence Agency • Court Documentation (within the last year) 		
Proof of Student Status	<ul style="list-style-type: none"> • Current transcript 		
Proof of Education eight grade and below	<ul style="list-style-type: none"> • Written Statement from applicant/School Transcript 		
Proof of Parental Disability	<ul style="list-style-type: none"> • Written SSI recipient letter/Doctor’s statement 		
Proof of Pregnancy	<ul style="list-style-type: none"> • Written Medical Documentation (current) 		
Proof of Public Housing Residency	<ul style="list-style-type: none"> • MDPHA Written Rental/Lease Agreement 		
Proof of Foster Care/Legal Custody	<ul style="list-style-type: none"> • Documentation from Foster Care Agency/ Court Award 		
Proof of Guardianship/Legal Custody	<ul style="list-style-type: none"> • Documentation from Court System/ Court Award 		

Parents will certify that the information provided on the application and supporting documentation is true and correct and that all parent(s)/legal guardian(s) income are reported. Deliberate misrepresentation of any information submitted may be subject to the child being terminated from the program. An incomplete application and documentation will delay the enrollment process.

Documentation provided: STAFF NAME/DATE _____

Documentation provided): STAFF NAME/DATE _____

Documentation provided STAFF NAME/DATE _____

Application



Miami-Dade Community Action and Human Services Department Head Start / Early Head Start Family Information



Primary Adult Name: _____

Birthday: _____

Eligible Child Name: _____

Birthday: _____

General Information:

Living Address:	City	State	Zip	County
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Mailing Address (if different):	City	State	Zip
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Phone Number	Home, Work, Cell, etc.	Primary	Notes
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	

Number in Household _____ Num. in Family _____ Total Num. of Children _____ Num. Age 0-3 _____ Num. Age 4-5 _____
(Living with Child) (Supported by the income of parent or guardian)

Parental Status: <input type="checkbox"/> One <input type="checkbox"/> Two	Primary Language at Home:	Center Applying for:
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Family Income – Time period income based on: Previous 12 Months Last Calendar Year

TANF Yes No Formerly SSI Yes No WIC Yes No WIC ID _____

Income Source	Frequency
Non-Agricultural Earned Income (i.e. wages, tips)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Agricultural Earned Income (i.e. wages, tips)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Public Assistance, Welfare (i.e. TANF, AFDC)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Social Security Pension / Retirement	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Supplemental Security Insurance (SSI)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Foster Care/Adoption Subsidy	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Unemployment Compensation	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Child Support/Alimony	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Other Unearned Income	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month

Income Notes: _____

Emergency Contacts: (please complete carefully)

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____ Phone #: _____ Phone #: _____

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____ Phone #: _____ Phone #: _____

Medical / Dental Providers: (please complete carefully)

Doctor: Yes * No * (Staff Use Only) Referred to: _____ Date: _____ Referred by: _____

Doctor Name: _____ Address: _____ Phone #: _____

Dentist: Yes * No * (Staff Use Only) Referred to: _____ Date: _____ Referred by: _____

Dentist Name: _____ Address: _____ Phone #: _____



**Miami-Dade Community Action and Human Services Department
Head Start / Early Head Start
Family Member Information**



Primary Adult (Parent/Legal Guardian):

Last	First	Middle	Birthday	Gender
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Lives with Family
 Provides Financial Support
 Teen Parent

Highest Grade Completed: _____ Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed	Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin	English Proficiency: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: _____ <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
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Secondary Adult (Parent/Legal Guardian):

Last	First	Middle	Birthday	Gender
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Lives with Family
 Provides Financial Support
 Teen Parent

Highest Grade Completed: _____ Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed	Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin	English Proficiency: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: _____ <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
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Other Family Members (Supported by the income of parent or guardian):

Adult/Child	Last	First	Birthday	Gender	Relationship

Application/ Referral Source (required):

- Child Development Services
 Child Welfare Agency
 Community Outreach
 Court Ordered Referral
 Department of Children & Families
 Disability Program
 Early Head Start
 Family/Friend
 Flea Market
 Former Parent
 Hospital/Health Clinic
 Healthy Start
 Hotline
 Public Housing
 Public or Private Non-Profit Organization
 Public Schools
 Resource & Referral Agency
 Self Referral
 South Florida Workforce
 Unemployment
 WIC
 Youth Fair
 Other (specify): _____

Verification (signature required): Please Read Before Signing

I certify that the information provided in this application package, and the proof of income provided for enrollment eligibility, is accurate and truthful to the best of my knowledge. Providing false income/information could result in dismissal from the program.

Parent or Guardian Signature: _____ Date: ____/____/____

Parent or Guardian Print Name: _____



**Miami-Dade Community Action and Human Services Department
Head Start / Early Head Start
Eligible Child Information**



Eligible Child (New Enrollee):

Last	First	Middle	Preferred / Nickname	Suffix
Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Proof of age verified	Source of age verification:	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	English Proficiency: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Medicaid Eligibility: <input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible	
	Other Language Spoken: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Medicaid Number: _____	
	Primary Adult Relationship to Child: <input type="checkbox"/> Custody <input type="checkbox"/> Foster* <input type="checkbox"/> Grandchild* <input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step <input type="checkbox"/> Niece* <input type="checkbox"/> Nephew* <input type="checkbox"/> Other* (specify) _____		Health Insurance Information: Name/Number: _____ <input type="checkbox"/> Other/Private Health Coverage(list name of provider): _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin	Secondary Adult Relationship to Child: <input type="checkbox"/> Custody <input type="checkbox"/> Foster* <input type="checkbox"/> Grandchild* <input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step <input type="checkbox"/> Niece* <input type="checkbox"/> Nephew* <input type="checkbox"/> Other* (specify) _____		<input type="checkbox"/> No Health Coverage Referral completed to: _____	
Nationality: _____	* Legal court documentation is required to enroll child. Is there a current Order of Protection or No Contact order which concerns this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		Kidcare Application Completed Date: _____ Staff: _____ Date: _____	

(Medical Provider): Does the child have an ongoing source of continuous, accessible medical care? Yes No

(Dental Provider): Does the child have an ongoing source of continuous, accessible dental care? Yes No

Assistive Devices Used: Glasses Contact Lenses Crutches Walker Cane Wheelchair Braces Hearing Aides No Assistive Devices

Health Concerns: Yes Provide written documentation No

Describe: _____

Diagnosed Disability with IEP (HS) or IFSP (EHS): Yes No Date: _____ **Diagnosed Disability with Professional Diagnosis:** Yes No

Family Circumstances: (please complete carefully)

Family Demographics:	Yes	No	Parental Status:	Yes	No
Place check <input checked="" type="checkbox"/> in appropriate box			Place check <input checked="" type="checkbox"/> in appropriate box		
Documented Substance abuse			One Parent		
Documented Domestic Violence			Two Parents		
Documented Parent education <8 th grade			Foster Parent		
Documented Teen Parent <17 years old			Legal Guardian		
Homeless Length of time homeless: _____ Agency: _____			Family Services: Place check <input checked="" type="checkbox"/> in appropriate box		
Documented Pregnant Women			Medicaid/Medicare		
Documented Public Housing Resident (MPHA)			Food Stamps		
Documented Parental Disability			WIC		
Transition from Early Head Start to Head Start			Public Assistance/ Welfare		
Documented Working Parent / Student			TANF/AFDC		
Retuning Sibling(s) in Head Start/Early Head Start			Supplemental Security Income (SSI)		
Documented -Court Ordered Referred			Documented Foster Program Referred		



**Miami-Dade Community Action and Human Services Department
Head Start / Early Head Start
Family Demographic/Eligibility Information
(Office Use Only)**



1. Primary Adult Name _____ Birthday _____
2. Eligible Child Name _____ Birthday _____
3. Child's date of enrollment into program: _____ Child's date of entry into program: _____
4. Earned Income Annual Amount \$ _____ Unearned Income Annual Amount \$ _____
5. Verify Eligibility - Check which category of eligibility this child falls into:
 - Income
 - Below federal poverty guidelines
 - Between 100-130% federal poverty guidelines
 - Over income
 - Public Assistance
 - Homeless
 - Foster Care
6. Family Size : (provide the family members supported by the income of the parent(s) of the eligible child listed above): _____
7. What documentation was used to determine eligibility:

<input type="checkbox"/> Income Tax Form 1040 (last calendar year) W-2	<input type="checkbox"/> Written statements from employers
<input type="checkbox"/> Public Aid / TANF-documentation	<input type="checkbox"/> Foster care reimbursement
<input type="checkbox"/> Pay stubs	<input type="checkbox"/> SSI documentation
<input type="checkbox"/> W-2 (last calendar year)	<input type="checkbox"/> Social Security
<input type="checkbox"/> Grants/Scholarships/Financial Aid	<input type="checkbox"/> Child Support
<input type="checkbox"/> Unemployment	<input type="checkbox"/> Other

Documentation of no income: _____

Staff Income Verification signature (required):

I have examined the income documents checked above and certify that the child is income and age eligible to participate in the program.

Staff Signature: _____ Date of Eligibility Verification: _____

Staff name printed: _____ Title: _____

Center Director Signature: _____ Date: _____