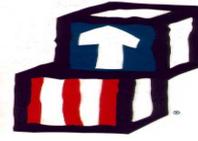




**3 – 5 YEARS OLD**



**MIAMI DADE COUNTY  
COMMUNITY ACTION AGENCY  
HEAD START/EARLY HEAD START  
REGISTRATION REQUIREMENTS**

**Dear Parents (s):**

**The following items are needed before completing the Head Start/Early Head Start application process:**

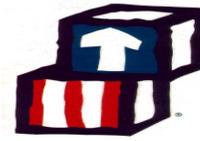
- 1. Your child's birth certificate. Children must be 3 or 4 years of age on or before September 1, 2011, or no more than five (5) years old after September 1, 2010.**
- 2. Proof of parent's/legal guardian gross income for the past 12 months or the last calendar year (2010). Documents include a signed Income Form Tax 1040, W-2 forms, pay stubs, pay envelopes, Unemployment Compensation, written statements from employers, or documentation showing current status as recipients of public assistance, Social Security Supplemental Income (SSI), TANF, or Child Support.**
- 3. Picture identification of parent(s)/legal guardian – driver's license, state issued picture, employer issued I.D.**
- 4. Proof of Dade County Residency.**
- 5. If your child has a diagnosed disability, you must attach the Individualized Education Plan (IEP) or the Individualized Family Support Plan or evaluation report (IFSP). Disabled child are eligible for the Head Start Program on or after their third (3<sup>rd</sup>) birth date.**

**Note: In order to ensure that your child receives proper care and attention, inform the Head Start staff during registration, if your child has any allergies, special medical or dietary needs, or other areas of concern.**

**All information returned to the Head Start/Early Head Start Program will be maintained in a confidential manner.**



## **0-3YEARS OLD & PREGNANT WOMEN**



### **MIAMI DADE COUNTY COMMUNITY ACTION AGENCY HEAD START/EARLY HEAD START REGISTRATION REQUIREMENTS**

**Dear Parents (s):**

**The following items are needed before completing the Head Start/Early Head Start application process:**

- 1. Proof of pregnancy – Doctor’s note; Proof of age - child’s birth certificate.**
- 2. Proof of family gross income for the past 12 months or the last calendar year. Documents include a signed Income Form Tax 1040, W-2 forms, pay stubs, pay envelopes, Unemployment Compensation, written statements from employers, or documentation showing current status as recipients of public assistance, Social Security Supplemental Income (SSI), TANF, or Child Support.**
- 3. Picture identification of parent(s)/legal guardian – driver’s license, state issued picture, employer issued I.D.**
- 4. Proof of Dade County Residency.**
- 5. If your child has a diagnosed disability, you must attach the Individualized Education Plan (IEP) or the Individualized Family Support Plan or evaluation report (IFSP). Disabled child are eligible for Early Head Start (0-3 years old and Head Start on or after their third (3<sup>rd</sup>) birth date.**

**Note: In order to ensure that your child receives proper care and attention, inform the Early Head Start staff during registration, if your child has any allergies, special medical or dietary needs, or other areas of concern.**

**All information returned to the Head Start/Early Head Start Program will be maintained in a confidential manner.**



# Miami-Dade Community Action Agency 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	
---------------------------------	------	-------	-----	--

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:
---	---------------------------	----------------------

**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 Agency Head Start / Early Head Start Family Member Information



Primary Adult:				
Last	First	Middle	Birthday	Gender

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

Secondary Adult:				
Last	First	Middle	Birthday	Gender

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

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):**

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 Agency Head Start / Early Head Start Eligible Child Information



**Eligible Child:**

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:	
<b>Race:</b> <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	<b>English Proficiency:</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<b>Medicaid Eligibility:</b> <input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible	
	<b>Other Language Spoken:</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Medicaid Number: _____ Insurance Number: _____ <input type="checkbox"/> Other/Private Health Coverage(list name of provider): _____ _____ <input type="checkbox"/> No Health Coverage Referral completed to: _____ _____ Kidcare Application Completed Date: _____ Staff: _____ Date: _____	
<b>Ethnicity:</b>  <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin	<b>Primary Adult Relationship to Child:</b> <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) _____			
<b>Nationality:</b> _____	<b>Secondary Adult Relationship to Child:</b> <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) _____			
* Legal court documentation is required to enroll child. <b>Is there a current Order of Protection or No Contact order which concerns this child?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

**(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 <sup>th</sup> grade			Foster Parent		
Documented Teen Parent <17 years old			Legal Guardian		
Homeless Length of time homeless: _____ Source: _____			<b>Family Services:</b> Place check <input checked="" type="checkbox"/> in appropriate box		
Documented Pregnant Women			Medicaid/Medicare		
Documented Public Housing Resident			Food Stamps		
Documented Parental Disability			WIC		
Transition from Early Head Start to Head Start			Public Assistance/ Welfare		
Documented Working Parent / Student			TANF/AFDC		
KIDCARE – Health Insurance			Supplemental Security Income (SSI)		
Documented -Court Ordered Referred			Documented Foster Program Referred		



**Miami-Dade Community Action Agency  
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 eligible to participate in the program.**

Staff Signature: \_\_\_\_\_ Date of Eligibility Verification: \_\_\_\_\_

Staff name printed: \_\_\_\_\_ Title: \_\_\_\_\_

Center Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_