



0 – 5 YEARS OLD



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

(Parent/Legal Guardian Copy)

Documentation for proof of birth, proof of income, Parent/Guardian picture ID and proof of Miami-Dade County residency is needed at the time of the application intake. This information is used to determine program eligibility. If “yes” was checked on the family circumstances checklist on page 2 of the application you must provide documentation for those items. Staff is available to assist with the completion of the application.

Proof of Age: <ul style="list-style-type: none"> • EHS - Pregnant women can be any age. Children: Birth to age 3 years after September 1, 2017. • HS - Children must be 3 or 4 years of age on or before September 1, 2017, or no more than five (5) years old after September 1, 2017. 	<ul style="list-style-type: none"> • Birth Certificate • Passport • Notarized Affidavit of Age Form • Doctor’s statement (pregnant women)
Proof of parent’s/legal guardian gross income for the past 12 months or the last calendar year (2016).	<ul style="list-style-type: none"> • Signed Income Tax 1040 with eligible child name listed • W-2 form(s) • pay stubs • Unemployment Compensation • Written statement from employers on letterhead • Social Security Supplemental Income (SSI) print-out • TANF print-out • Child Support Agency • Income Statement Form
Proof of Parent’s Identification	<ul style="list-style-type: none"> • Driver’s license/Passport • State issued picture I.D. • Employer issued I.D./Military I.D. • Homeless Shelter I.D.
Proof of Dade County Residency	<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/or Mortgage Agreement • TANF/SSI/Unemployment Letter
Proof of Disability	<ul style="list-style-type: none"> • Individualized Educational Plan (IEP) • Individualized Family Support Plan IFSP
Proof of Suspected Disability	<ul style="list-style-type: none"> • Doctor/Therapist evaluations and statements outlining concerns
Proof of Homelessness Verification	<ul style="list-style-type: none"> • Statement from homeless facility or social worker • Statement from applicant
Proof of Substance Abuse	<ul style="list-style-type: none"> • Statement from Treatment Program Staff
Proof of Domestic Violence	<ul style="list-style-type: none"> • Statement from Domestic Violence Agency/Staff • Court Documentation (within the last year)
Proof of Student Status	<ul style="list-style-type: none"> • Current Transcript/Class Schedule
Proof of Education Eight Grade and Below	<ul style="list-style-type: none"> • Statement from Applicant/Official School Transcript
Proof of Parental Disability	<ul style="list-style-type: none"> • SSI Recipient Letter/Doctor’s Statement
Proof of Pregnancy	<ul style="list-style-type: none"> • Medical Documentation (current)
Proof of Public Housing Residency	<ul style="list-style-type: none"> • MDPHA Rental/Lease Agreement
Proof of Foster Care-Legal Custody	<ul style="list-style-type: none"> • Documentation from Foster Care Agency/Court Award
Proof of Legal Guardianship/Custody	<ul style="list-style-type: none"> • Documentation from the Court System/Court Award

Parents must verify 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 result in the child being terminated from the program. An incomplete application and missing documentation will delay the enrollment process.



Office Use Only
(Checked upon receipt of Documentation)



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

		Yes	No
Proof of Age : • EHS - Birth to age 3 years after September 1, 2017. • HS - Children must be 3 or 4 years of age on or before September 1, 2017, or no more than five (5) years old after September 1, 2017.	<ul style="list-style-type: none"> • Birth Certificate • Passport • Notarized Affidavit of Age Form • Doctor's statement (pregnant women) 		
Proof of parent's/legal guardian gross income for the past 12 months or the last calendar year (2016).	<ul style="list-style-type: none"> • Signed Income Tax 1040 with eligible child name listed • W-2 form(s) • pay stubs • Unemployment Compensation • Written statement from employers on letterhead • Social Security Supplemental Income (SSI) print-out • TANF print-out • Child Support Agency • Income Statement Form 		
Proof of Parent's Identification	<ul style="list-style-type: none"> • Driver's license/Passport/I.D. from Homeless Shelter • State issued picture I.D. • Employer issued I.D. • Military I.D. 		
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 and/or 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 Caret/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** _____



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



Primary Adult Name: _____

Birthdate: _____

Eligible Child Name: _____

Birthdate: _____

General Information:

Living Address:	City	State	Zip Code	County: MIAMI-DADE
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Mailing Address (if different):	City	State	Zip Code
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Phone Number(s)	Home, Work, Cellular, E-mail	Primary	Notes

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

Parental Status: <input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster* <input type="checkbox"/> Legal Guardian* <input type="checkbox"/> Grandparent* <input type="checkbox"/> Niece/Nephew* <input type="checkbox"/> Other, specify* _____ <input type="checkbox"/> One parent <input type="checkbox"/> Two parents * Legal court documentation is required to enroll child.	Primary Language of family at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> African <input type="checkbox"/> European & Slavic <input type="checkbox"/> Pacific Island <input type="checkbox"/> East Asian <input type="checkbox"/> Middle Eastern & South Asian <input type="checkbox"/> Native North American /Alaskan <input type="checkbox"/> North Central American, South American <input type="checkbox"/> Other: _____	Center Applying for:
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Family Income:

TANF: Yes No Formerly **SSI:** Yes No **Food Stamps/SNAP:** Yes No **WIC:** Yes No **WIC ID#** _____

Income Source	Frequency
Earned Income (1040, W-2, pay stubs, employer letter)	<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 Reimbursement	<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, explain:	<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)

(Medical Provider): Does the child have an on-going source of continuous, accessible medical care (medical home)? **Yes** **No**

Doctor Name: _____ **Address:** _____ **Phone #:** _____

If No Doctor* *STAFF USE ONLY **Staff Person Referred by:** _____
(Staff Referred TO Medical Provider): _____ **Date:** _____

(Dental Provider): Does the child have an on-going source of continuous, accessible dental care (dental home)? **Yes** **No**

Dentist Name: _____ **Address:** _____ **Phone #:** _____

If No Dentist* *STAFF USE ONLY **Staff Person Referred by:** _____
(Staff Referred TO Dental Provider): _____ **Date:** _____

STAFF USE ONLY



**Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division
ELIGIBLE CHILD INFORMATION**



Eligible Child (New Enrollee):							
Last		First		Middle			
Nickname		Suffix					
Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Proof of age verified: <input type="checkbox"/> Yes <input type="checkbox"/> No		Source of age verification: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Doctor Statement (Pregnant Woman) <input type="checkbox"/> Notarized Affidavit of Age <input type="checkbox"/> Other(Specify):			
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 <input type="checkbox"/> Bi-racial/Multi-racial Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin Nationality: _____		English Proficiency: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Medicaid Eligibility: <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible <input type="checkbox"/> Not Eligible Medicaid Number: _____			
		Other Language Spoken: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Health Care Provider Name: _____ Insurance Number: _____ <input type="checkbox"/> Other/Private Health Coverage(list name of provider): _____			
		Primary Adult Relationship to Child: <input type="checkbox"/> Biological <input type="checkbox"/> Grandchild * <input type="checkbox"/> Foster* <input type="checkbox"/> Adopted* <input type="checkbox"/> Step Child <input type="checkbox"/> Niece/Nephew * <input type="checkbox"/> Legal Guardian* <input type="checkbox"/> Other* (specify) _____		<input type="checkbox"/> No Health Insurance Coverage Referral completed to: _____ Florida KidCare Application Completed Date: _____ Staff: _____ Date: _____			
Secondary Adult Relationship to Child: <input type="checkbox"/> Biological <input type="checkbox"/> Grandchild* <input type="checkbox"/> Foster* <input type="checkbox"/> Adopted* <input type="checkbox"/> Step Child <input type="checkbox"/> Niece/Nephew* <input type="checkbox"/> Legal Guardian* <input type="checkbox"/> Other *(Specify) _____		Is there a current Order of Protection or No Contact Order which concerns this child? <input type="checkbox"/> Yes <input type="checkbox"/> No * Legal court documentation is required to enroll child.					
Special Needs/Disability:							
Miami-Dade County Public School Diagnosed Disability Evaluation-Individualized Education Plan (IEP):				<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES Date:		
Early Steps Program-Individualized Family Support Plan (IFSP):			<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES Date:			
Professional Diagnosis (speech therapy, occupational, etc.):			<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES Date:			
Assistive Devices Used: <input type="checkbox"/> No Assistive Devices <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Hearing Aides							
Health Services:							
Does your child receive medical treatment for : <input type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> High Lead Level <input type="checkbox"/> Other, specify:							
<input type="checkbox"/> No medical treatment							
List all known allergies, dietary needs or other medical/dental areas of concerns: Describe:							
<input type="checkbox"/> None known							
Family Circumstances: (please complete carefully)							
Family Demographics: Place check <input checked="" type="checkbox"/> in appropriate box		Yes	No	Parental Status: Place check <input checked="" type="checkbox"/> in appropriate box		Yes	No
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:			Family Services: Place check <input checked="" type="checkbox"/> in appropriate box		Yes	No
Agency Name:							
Documented Pregnant Women				Medicaid/ Florida KidCare			
Documented Public Housing Resident (MPHA)				Food Stamps/SNAP			
Documented Parental Disability				WIC			
Transition from Early Head Start to Head Start				Public Assistance/ Welfare TANF/AFDC			
Documented Working Parent / Student				Supplemental Security Income (SSI)			
Returning Sibling(s) in Head Start/Early Head Start				Referred from a Foster Program			
Documented –Referred for services by a child welfare agency				Referred from Florida Department of Children and Families or Court Ordered			



**Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division
FAMILY MEMBER INFORMATION**



Primary Adult (Parent/Legal Guardian):				
Last	First	Middle	Birthdate	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Lives with Family <input type="checkbox"/> Custody <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent				
Language Proficiency:		Race:		Education:
English <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: _____ <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<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 <input type="checkbox"/> Bi-racial/Multi-racial		<input type="checkbox"/> An advanced degree or baccalaureate degree <input type="checkbox"/> An associate degree, vocational school, or some college <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> 9 th – 12 th grade <input type="checkbox"/> less than 8 th grade
Job Training/School:		Ethnicity:		
<input type="checkbox"/> Is in job training or school <input type="checkbox"/> Is NOT in job training or school		<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin		

Secondary Adult (Parent/Legal Guardian):				
Last	First	Middle	Birthdate	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Lives with Family <input type="checkbox"/> Custody <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent				
Language Proficiency:		Race:		Education:
English <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: _____ <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<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 <input type="checkbox"/> Bi-racial/Multi-racial		<input type="checkbox"/> An advanced degree or baccalaureate degree <input type="checkbox"/> An associate degree, vocational school, or some college <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> 9 th – 12 th grade <input type="checkbox"/> less than 8 th grade
Job Training/School:		Ethnicity:		
<input type="checkbox"/> Is in job training or school <input type="checkbox"/> Is NOT in job training or school		<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin		

EMPLOYMENT: (Parents/Legal Guardians)	
Primary Adult: <input type="checkbox"/> Is EMPLOYED Effective date: _____ <input type="checkbox"/> Is UNEMPLOYED (i.e. not working, retired, or disabled) Effective date: _____ <input type="checkbox"/> Member of U.S. Military <input type="checkbox"/> Military Veteran <input type="checkbox"/> N/A	Secondary Adult: <input type="checkbox"/> Is EMPLOYED: Effective date: _____ <input type="checkbox"/> Is UNEMPLOYED (i.e. not working, retired, or disabled) Effective date: _____ <input type="checkbox"/> Member of U.S. Military <input type="checkbox"/> Military Veteran <input type="checkbox"/> N/A

Other Family Members (Supported by the income of the parent or legal guardian):					
Adult/Child	Last	First	Birthdate	Gender	Relationship to Child
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	

Application/ Referral Source (required):

- Early Learning Coalition
 MCI
 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
 WIC
 Unemployment
 Youth Fair
 Other (specify): _____

Verification (signature required): *Please Read Before Signing*

I verify that the information provided in this application package, and the proof of age and income provided for enrollment eligibility, is accurate and truthful to the best of my knowledge. I am aware that providing false income/information could result in dismissal from the program.	
Parent/Guardian Print Name: _____	Date: _____
Parent/Guardian Signature: _____	Date: _____