



0 – 5 YEARS OLD



Miami-Dade County
Community Action and Human Services Department
HEAD START/EARLY HEAD START PROGRAM
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.

ALL DOCUMENTS MUST BE CURRENT AT TIME OF SUBMISSION:

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, 2018. • HS - Children must be at least 3 years old on or before September 1, 2018, or no more than five (5) years old after September 1, 2018. 	<ul style="list-style-type: none"> • Birth Certificate • Passport • Signed Hospital Foot Print Certificate • Notarized Affidavit of Age Form • Doctor’s statement (pregnant women)
Proof of parent’s/legal guardian gross income for the <u>past 12 months or the last calendar year (2017)</u>.	<ul style="list-style-type: none"> • Signed Income Tax 1040 • 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 Miami-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/Custody-order
Proof of Legal Guardianship/Custody	<ul style="list-style-type: none"> • Documentation from the Court System/Custody-order

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.



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



Primary Adult Name: _____

Birthdate: _____

Eligible Child Name: _____

Birthdate: _____

General Information:						
Living Address:			City	State	Zip Code	County: MIAMI-DADE
Mailing Address (if different):			City	State	Zip Code	
Phone Number(s)	Home, Work, Cellular, E-mail	Primary	Notes			
		<input checked="" type="checkbox"/>				
Number in Household ____ Number in Family ____ Total Number(s) of Children ____ Age(s) 0-3 ____ Age(s) 4-5 ____ Age(s) 6 & above ____ <small>(Living with Child) (Supported by the income of parent or guardian)</small>						
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, must specify: _____		Center Applying for: _____ _____		

HS/EHS STAFF USE ONLY	Family Income:	
	TANF: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly SSI: <input type="checkbox"/> Yes <input type="checkbox"/> No Food Stamps/SNAP: <input type="checkbox"/> Yes <input type="checkbox"/> No WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No WIC ID# _____	
	Income Sources:	Amount:
		Frequency:
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually
For example: Earned income: 1040, W-2, pay stubs, employer letter, Social Security Pension/Retirement, Unemployment Compensation, court-ordered Child Support/Alimony. Unearned income: Public Assistance (i.e. TANF or SSI), Foster Care Reimbursement and if Other, please specify.		Total Income:
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)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctor Name:	Address: _____ Phone #: _____
<input type="checkbox"/> If No Doctor* *STAFF USE ONLY	Date: _____ Staff Name: _____
(Dental Provider): Does the child have an on-going source of continuous, accessible dental care (dental home)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name:	Address: _____ Phone #: _____
<input type="checkbox"/> If No Dentist* *STAFF USE ONLY	Date: _____ Staff Name: _____



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



Eligible Child (New Participant):						
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 Other Language Spoken: <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: _____ Health Care Provider Name: _____ Insurance Number: _____ <input type="checkbox"/> Other/Private Health Coverage (list name of provider): _____ <input type="checkbox"/> No Health Insurance Coverage Referral completed to: _____ Florida KidCare Application Completed Date: _____ Staff: _____ Date: _____			
	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) _____					
	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)						
Place check <input checked="" type="checkbox"/> in appropriate box	Yes	No	Place check <input checked="" type="checkbox"/> in appropriate box	Yes	No	
Documented Substance abuse			Homelessness: Length of time homeless: _____ Agency Name: _____			
Documented Domestic Violence			If Yes, explain:			
Documented Parent education <8 th grade			ELC-Child Care Subsidy Voucher (EHS-CCP only) If Yes Date: _____			
Documented Teen Parent <17 years old			No apparent Social Service or Special Needs			
Documented Public Housing Resident (MPHA)			Notes:			
Documented Working Parent / Student						
Documented Parental Disability			**Application Referral Source: (required)			
Returning Sibling(s) in Head Start/Early Head Start			<input type="checkbox"/> Early Learning Coalition <input type="checkbox"/> MCI <input type="checkbox"/> Community Outreach <input type="checkbox"/> Disability Program <input type="checkbox"/> Court-Ordered Referral <input type="checkbox"/> Department of Children & Families <input type="checkbox"/> Early Head Start <input type="checkbox"/> Family/Friend <input type="checkbox"/> Former Parent <input type="checkbox"/> Hospital/Health Clinic <input type="checkbox"/> Healthy Start <input type="checkbox"/> Hotline <input type="checkbox"/> Public Housing <input type="checkbox"/> Public or Private Non-Profit Organization <input type="checkbox"/> Public Schools <input type="checkbox"/> Resource & Referral Agency <input type="checkbox"/> Self-Referral <input type="checkbox"/> South Florida Workforce <input type="checkbox"/> WIC <input type="checkbox"/> Unemployment Agency <input type="checkbox"/> Youth Fair <input type="checkbox"/> HS/EHS Flyer <input type="checkbox"/> Other (Please, specify): _____			
Transition from Early Head Start to Head Start						
Displaced families due to disasters						
Documented Pregnant Woman						
Documented –Referred for services by a child welfare agency						



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"/> Provides Financial Support				
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"/> Provides Financial Support				
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
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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	
<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	

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 eligibility determination is accurate and truthful to the best of my knowledge. I am aware that providing false income/age information could result in dismissal from the program.

Parent/Guardian Print Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____