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.

Proof of Age: EHS- Pregnant women. Birth to age 3 years after September 1, 2013. HS- Children must be 3 or 4 years of age on or before September 1, 2013, or no more than five (5) years old after September 1, 2013.	• **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 (2012).	• **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**
Proof of Parent's Identification	• **Driver's license/Passport** • **State issued picture I.D.** • **Employer issued I.D./Military ID** • **Homeless Shelter ID**
Proof of Dade County Residency	• **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**
Proof of Disability	• **Individualized Educational Plan (IEP)** • **Individualized Family Support Plan IFSP**
Proof of Suspected Disability	• **Doctor/Therapist evaluations and statements outlining concerns**
Proof of Homelessness Verification	• **Statement from homeless facility or social worker** • **Statement from applicant**
Proof of Substance Abuse	• **Statement from Treatment Program Staff**
Proof of Domestic Violence	• **Statement from Domestic Violence Agency/Staff** • **Court Documentation (within the last year)**
Proof of Student Status	• **Current Transcript**
Proof of Education Eight Grade and Below	• **Statement from Applicant/Official School Transcript**
Proof of Parental Disability	• **SSI Recipient Letter/Doctor's Statement**
Proof of Pregnancy	• **Medical Documentation (current)**
Proof of Public Housing Residency	• **MDPHA Rental/Lease Agreement**
Proof of Foster Care-Legal Custody	• **Documentation from Foster Care Agency/Court Award**
Proof of Legal Guardianship/Custody	• **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)

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

		Y	N
Proof of Age : EHS- Birth to age 3 years after September 1, 2013. HS -Children must be 3 or 4 years of age on or before September 1, 2013, or no more than five (5) years old after September 1, 2013)	• 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 (2012)</u>.	• 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	• Driver's license/Passport/ID from Homeless Shelter • State issued picture I.D. • Employer issued I.D. • Military ID		
Proof of Dade County Residency	• 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	• Individualized Educational Plan (IEP) /IFSP		
Proof of Suspected Disability	• Doctor's Statement outlining concerns		
Proof of Homelessness	• Written Statement from Homeless Facility		
Proof of Substance Abuse	• Written Statement from Treatment Program		
Proof of Domestic Violence	• Written Statement from Domestic Violence Agency • Court Documentation (within the last year)		
Proof of Student Status	• Current transcript		
Proof of Education eight grade and below	• Written Statement from applicant/School Transcript		
Proof of Parental Disability	• Written SSI recipient letter/Doctor's statement		
Proof of Pregnancy	• Written Medical Documentation (current)		
Proof of Public Housing Residency	• MDPHA Written Rental/Lease Agreement		
Proof of Foster Caret/Legal Custody	• Documentation from Foster Care Agency/ Court Award		
Proof of Guardianship/Legal Custody	• 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
Mailing Address (if different):	City	State	Zip	

Phone Number	Home, Work, Cell, E-mail	Primary	Notes
		☐	
		☐	
		☐	

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

Parental Status:	Primary Language at Home:	Center Applying for:
☐ Natural/Adopted/Stepparent ☐ Foster ☐ Grandparent ☐ Niece/Nephew ☐One parent ☐Two parents		

Family Income – Time period income based on: ☐ Previous 12 Months ☐ Last Calendar Year

TANF ☐Yes ☐No ☐Formerly SSI ☐Yes ☐No Food Stamps/SNAP ☐Yes ☐No WIC ☐Yes ☐No WIC ID _____

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

☐ Lives with Family ☐ Custody ☐ Provides Financial Support ☐ Teen Parent

Employment Status:
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time& Training
☐ Retired ☐ Disabled
☐ Training or School ☐ US Military
☐ Seasonally Employed
☐ Unemployed

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient
Other Language Spoken:_____
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Latino Origin

Education:
☐ Associates ☐Bachelors ☐ Masters
☐ College Degree/Training
☐ College Degree or advance Training
☐ 9th grade or less ☐10th grade ☐ 11th grade ☐12th Grade
☐ High School

Secondary Adult (Parent/Legal Guardian):

Last	First	Middle	Birthday	Gender

☐ Lives with Family ☐ Custody ☐ Provides Financial Support ☐ Teen Parent

Employment Status:
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time& Training
☐ Retired ☐ Disabled
☐ Training or School ☐ US Military
☐ Seasonally Employed
☐ Unemployed

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient
Other Language Spoken:_____
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Latino Origin

Education:
☐ Associates ☐Bachelors ☐ Masters
☐ College Degree/Training
☐ College Degree or advance Training
☐ GED ☐ 9th grade or less ☐10th grade ☐ 11th grade ☐12th Grade
☐ 9th grade or less ☐ High School

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

Birthday	Gender ☐ M ☐ F	☐ Proof of age verified	Source of age verification:

Race:

☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity:

☐ Hispanic or Latino Origin

☐ Non-Hispanic or Latino Origin

Nationality:_____

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Primary Adult Relationship to Child: ☐ Custody

☐ Foster* ☐ Grandchild * ☐ Biological ☐ Adopted*
☐ Step ☐ Niece* ☐ Nephew *
☐ Other*
(specify)_____

Secondary Adult Relationship to Child: ☐ Custody

☐ Foster* ☐ Grandchild* ☐ Biological ☐ Adopted*
☐ Step ☐ Niece* ☐ Nephew*
☐ Other*
(specify)_____

*** Legal court documentation is required to enroll child.**
Is there a current Order of Protection or No Contact order which concerns this child? ☐ Yes ☐ No

Medicaid Eligibility:
☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible

Medicaid Number:_____

Health Insurance Information:

Name//Number:_____

☐ Other/Private Health Coverage(list name of provider):

_____

☐ No Health insurance Coverage

Referral completed to:

_____

Kidcare Application Completed Date:_____
Staff:_____ Date: _____

Special Needs/Disability:

Miami Dade County Schools Diagnosed Disability Evaluation -Individualized Education Plan (IEP): ☐ Yes ☐ No Date: ___

Early Steps Program individualized Family Support Plan (IFSP): Yes ☐ No ☐ Date: _____

Professional Diagnosis (speech therapy, occupational, etc.): Yes ☐ No ☐ 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: No ☐ Yes ☐ Provide written documentation Describe: _____

Family Circumstances: (please complete carefully)

Family Demographics: Place check ☑ in appropriate box	Yes	**No**	**Parental Status:** Place check ☑ in appropriate box	Yes	**No**
Documented Substance abuse			One Parent		
Documented Domestic Violence			Two Parents		
Documented Parent education <8th grade			Foster Parent		
Documented Teen Parent <17 years old			Legal Guardian		
Homeless Length of time homeless: _____ Agency:_____			**Family Services:** Place check ☑ in appropriate box		
Documented Pregnant Women			Medicaid/Medicare		
Documented Public Housing Resident (MPHA)			Food Stamps/SNAP		
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 –Referred for services by a child welfare agency			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: _____ 1St Year Child's date of entry into program: _____

   2nd Year Child's date of entry into program: _____ 3rd Year 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 for the last twelve months or calendar year:

- ☐ Income Tax Form 1040 (last calendar year)
- ☐ Public Aid / TANF-documentation
- ☐ Pay stubs
- ☐ W-2 (last calendar year)
- ☐ Grants/Scholarships/Financial Aid
- ☐ Unemployment
- ☐ Written statements from employers
- ☐ Foster care reimbursement
- ☐ SSI documentation
- ☐ Social Security(last calendar year/12 months)
- ☐ Child Support
- ☐ 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: _____

Administrative Signature: _____ Date: _____