**0 – 5 YEARS OLD**

**MDCLogo_Color_lowres**

**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:**   * **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. | * **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).** | * **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** | * **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** | * **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** | * **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/Class Schedule** |
| **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 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 CAHSD Head Start/EHS – January 2017

**MDCLogo_Color_lowresOFFICE 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** - 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. | * 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).** | * 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** | * 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** | * 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** | * 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/Class Schedule |  |  |
| **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 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.

|  |  |  |
| --- | --- | --- |
| **Documentation provided:** | **STAFF NAME/DATE** |  |
| **Documentation provided:** | **STAFF NAME/DATE** |  |
| **Documentation provided:** | **STAFF NAME/DATE** |  |

Miami-Dade CAHSD Head Start/EHS – January 2017

******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** | | |
| **Mailing Address (if different): City State Zip Code** | | | | | | | | | | | | | | | | | | | | | | | | |
| **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:**  🞏 Biological/Adopted/Stepparent 🞏 Foster\*  🞏 Legal Guardian\* 🞏 Grandparent\*  🞏 Niece/Nephew\*  🞏 Other, specify\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ **Single parent** □ **Two-parent family**  **\* Legal court documentation is required to enroll child.**  **STAFF USE ONLY** | | | | | | **Primary Language of family at home:**  🞏 English 🞏 Spanish 🞏 Creole  🞏 African 🞏 European & Slavic 🞏 Pacific Island  🞏 East Asian 🞏 Middle Eastern & South Asian  🞏 Native North American /Alaskan  🞏 North Central American, South American  🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | **Center Applying for**: | | | | |
| 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) | | | | | | |  | | **□** Weekly **□** Monthly **□** Every 2 weeks **□** Annually **□** Twice a month | | | | | | | | | | | | | | | |
| TANF (public assistance) | | | | | | |  | | **□** Weekly **□** Monthly **□** Every 2 weeks **□** Annually **□** Twice a month | | | | | | | | | | | | | | | |
| Supplemental Security Insurance (public assistance) | | | | | | |  | | **□** Weekly **□** Monthly **□** Every 2 weeks **□** Annually **□** Twice a month | | | | | | | | | | | | | | | |
| Foster Care Reimbursement | | | | | | |  | | **□** Weekly **□** Monthly **□** Every 2 weeks **□** Annually **□** Twice a month | | | | | | | | | | | | | | | |
| Social Security Pension / Retirement | | | | | | |  | | **□** 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, explain: | | | | | | |  | | **□** 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)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **(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 Referred TO Medical Provider):** | | |  | | | | | | | | Date: |  | | | | Staff Person Referred by: | | | | |  | | | |
| **(Dental Provider):** Doe**s** 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 Referred TO Dental Provider)**: | | |  | | | | | | | | Date: |  | | | | Staff Person Referred by: | | | | |  | | | |

Miami-Dade CAHSD Head Start/EHS – January 2017 Page 1

******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:**  🞏 M 🞏 F | | **Proof of age verified**:  🞏 Yes 🞏 No | | | | **Source of age verification**:  🞏 Birth Certificate 🞏Passport 🞏Doctor Statement (Pregnant Woman)    🞏 Notarized Affidavit of Age 🞏 Other(Specify): | | | | | | | | | | |
| **Race:**  🞏 Asian  🞏 Black or African American  🞏 American Indian or Alaskan Native  🞏 Native Hawaiian or other Pacific Islander  🞏 White  🞏 Bi-racial/Multi-racial  **Ethnicity:**    🞏 Hispanic or Latino Origin  🞏 Non-Hispanic or Latino Origin  **Nationality**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **English Proficiency:**  🞏 None 🞏 Poor 🞏 Moderate 🞏 Proficient | | | | | | | | **Medicaid Eligibility:**  🞏 On Medicaid 🞏 Potentially Eligible  🞏 Not Eligible  Medicaid Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Health Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Insurance Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Other/Private Health Coverage(list name of provider):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 No Health Insurance Coverage  **Referral completed** **to:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Florida KidCare Application Completed Date:\_\_\_\_\_\_\_\_\_\_\_  Staff:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Other Language Spoken:**  🞏 None 🞏 Poor 🞏 Moderate 🞏 Proficient | | | | | | | |
| **Primary Adult Relationship to Child**:  🞏 Biological 🞏 Grandchild \* 🞏 Foster\* 🞏 Adopted\*  🞏 Step Child 🞏 Niece/Nephew \* 🞏 Legal Guardian\*  🞏 Other\* (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Secondary Adult Relationship to Child:**  🞏 Biological 🞏 Grandchild\* 🞏 Foster\* 🞏 Adopted\*  🞏 Step Child 🞏 Niece/Nephew\* 🞏 Legal Guardian\*  🞏 Other \*(Specify)\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Is there a current Order of Protection or No Contact Order which concerns this child? 🞏 Yes 🞏 No**    **\* Legal court documentation is required to enroll child.** | | | | | | | |
| **Special Needs/Disability:** | | | | | | | | | | | | | | | | | | |
| **Miami-Dade County Public School Diagnosed Disability Evaluation-Individualized Education Plan (IEP):** | | | | | | | | | | | | | 🞏 No 🞏 Yes | | **If YES Date:** | | | |
| **Early Steps Program-Individualized Family Support Plan (IFSP):** | | | | | | 🞏 No 🞏 Yes | | | | | **If YES Date:** | | | | | | | |
| **Professional Diagnosis (speech therapy, occupational, etc.):** | | | | | | 🞏 No 🞏 Yes | | | | | **If YES Date:** | | | | | | | |
| **Assistive Devices Used**: 🞏No Assistive Devices 🞏Glasses 🞏Contact Lenses 🞏Crutches 🞏Walker 🞏Cane 🞏Wheelchair 🞏Braces 🞏Hearing Aides | | | | | | | | | | | | | | | | | | |
| **Health Services:** | | | | | | | | | | | | | | | | | | |
| Does your child receive medical treatment for : 🞏 Anemia 🞏Asthma 🞏 Diabetes 🞏 High Lead Level 🞏Other, specify:  🞏 No medical treatment | | | | | | | | | | | | | | | | | | |
| List all known allergies, dietary needs or other medical/dental areas of concerns: **Describe:**  🞏 None known | | | | | | | | | | | | | | | | | | |
| **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 | | | | |  | |  | | Single Parent family | | | | | | |  | |  |
| Documented Domestic Violence | | | | |  | |  | | Two Parent family | | | | | | |  | |  |
| Documented Parent education <8th grade | | | | |  | |  | | Foster Parent | | | | | | |  | |  |
| Documented Teen Parent <17 years old | | | | |  | |  | | Legal Guardian | | | | | | |  | |  |
| Homeless:  Agency Name: | Length of time homeless: | | | |  | |  | | **Family Services:** Place check 🗹 in appropriate box | | | | | | | **Yes** | | **No** |
|  | | | |
| 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 CAHSD Head Start/EHS – January 2017 Page 2

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:**  🞏 Male 🞏 Female |
| □ **Lives with Family** □ **Custody** □ **Provides Financial Support** □ **Teen Parent** | | | | | | | | | | | | |
| **Language Proficiency:** | | | | **Race:** | | | | | **Education:** | | | |
| **English**  🞏 None 🞏 Poor 🞏 Moderate 🞏 Proficient  **Other Language Spoken**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 None 🞏 Poor 🞏 Moderate 🞏 Proficient | | | | 🞏 Asian  🞏 Black or African American  🞏 American Indian or Alaskan Native  🞏 Native Hawaiian or other Pacific Islander  🞏 White  🞏 Bi-racial/Multi-racial | | | | | 🞏 An advanced degree or baccalaureate degree  🞏 An associate degree, vocational school,  or some college  🞏 High school graduate or GED  🞏 9th – 12th grade  🞏 less than 8th grade | | | |
| **Job Training/School:** | | | | **Ethnicity:** | | | | |
| 🞏 Is in job training or school  🞏 Is **NOT** in job training or school | | | | 🞏 Hispanic or Latino Origin  🞏 Non-Hispanic or Latino Origin | | | | |
| Secondary Adult (Parent/Legal Guardian): | | | | | | | | | | | | |
| **Last** | | **First** | | | | **Middle** | | **Birthdate** | | | | **Gender:**  🞏 Male 🞏 Female |
| □ **Lives with Family** □ **Custody**  □ **Provides Financial Support** □ **Teen Parent** | | | | | | | | | | | | |
| **Language Proficiency**: | | | | **Race:** | | | | | **Education:** | | | |
| **English**  🞏 None 🞏 Poor 🞏 Moderate 🞏 Proficient  **Other Language Spoken**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 None 🞏 Poor 🞏 Moderate 🞏 Proficient | | | | 🞏 Asian  🞏 Black or African American  🞏 American Indian or Alaskan Native  🞏 Native Hawaiian or other Pacific Islander  🞏 White  🞏 Bi-racial/Multi-racial | | | | | 🞏 An advanced degree or baccalaureate degree  🞏 An associate degree, vocational school,  or some college  🞏 High school graduate or GED  🞏 9th – 12th grade  🞏 less than 8th grade | | | |
| **Job Training/School:** | | | | **Ethnicity:** | | | | |
| 🞏 Is in job training or school  🞏 Is **NOT** in job training or school | | | | 🞏 Hispanic or Latino Origin  🞏 Non-Hispanic or Latino Origin | | | | |
| **EMPLOYMENT: (Parents/Legal Guardians)** | | | | | | | | | | | | |
| **Primary Adult:**  🞏 Is **EMPLOYED** Effective date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Is **UNEMPLOYED** (i.e. not working, retired, or disabled)  Effective date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Member of U.S. Military 🞏 Military Veteran 🞏 N/A | | | | | **Secondary Adult:**  🞏 Is **EMPLOYED: E**ffective date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Is **UNEMPLOYED** (i.e. not working, retired, or disabled)  Effective date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Member of U.S. Military 🞏 Military Veteran 🞏 N/A | | | | | | | |
| Other Family Members (Supported by the income of the parent or legal guardian): | | | | | | | | | | | | |
| **Adult/Child** | **Last** | | **First** | | | | **Birthdate** | | | **Gender** | **Relationship to Child** | |
| 🞏Adult 🞏Child |  | |  | | | |  | | | 🞏 Male 🞏 Female |  | |
| 🞏Adult 🞏Child |  | |  | | | |  | | | 🞏 Male 🞏 Female |  | |
| 🞏Adult 🞏Child |  | |  | | | |  | | | 🞏 Male 🞏 Female |  | |
| 🞏Adult 🞏Child |  | |  | | | |  | | | 🞏 Male 🞏 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 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:** |  |

Miami-Dade CAHSD Head Start/EHS – January 2017 Page 3



Miami-Dade County

Community Action and Human Services Department

Head Start / Early Head Start

FAMILY DEMOGRAPHIC/INCOME ELIGIBILITY VERIFICATION

(*Office Use Only*)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | Primary Adult Name: |  | | | | | | | | | | Birthdate: | | |  | | | | | |
| 2. | Eligible Child Name: |  | | | | | | | | | | Birthdate: | | |  | | | | | |
| 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: | | | | | |  | | | | Total: | | |  |
| 5. | Verify Eligibility – Enrollment by Type of Eligibility: | | | | | | | |  | | CALCULATION AREA FOR INCOME  (IF NEEDED) | | | | | | | | | |
|  | * Income below 100% of federal poverty guidelines * *Over-Income* between 101-130% of federal poverty guidelines * *Over-Income* above 130% of federal poverty guidelines   **Relevant Time Period used for calculation of income:**  **🞏** Last Calendar Year \_\_\_\_\_\_\_\_ ***or***  **🞏** Previous 12 months \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * \*Homeless * \*Foster Care * \*Temporary Assistance to Needy Families (TANF) (Public Assistance) * \*Supplemental Security Income (SSI) (Public Assistance) | | | | | | | | | | | | | | | | | | | |
| 6. | Family Size: (Supported by the income of the parent(s) or legal guardian-see page 1 of application): | | | | | | | | | | | | |  | | | | |  | |
| 7. | What documentation was used to determine eligibility for the last twelve months or calendar year: | | | | | | | | | | | | | | |  | | | | |
|  | * Income Tax Form(s) 1040/1099 | | | | | | |  | * \*TANF documentation/Public Assistance | | | | | | | | | | | |
|  | * W-2 | | | | | | |  | * \*SSI documentation/Public Assistance | | | | | | | | | | | |
|  | * Written statements from employer(s) | | | | | | |  | * \*Homeless Shelter documentation | | | | | | | | | | | |
|  | * Pay Stub(s) | | | | | | |  | * \*Foster Care documentation | | | | | | | | | | | |
|  | * Grants/Scholarships | | | | | | |  | * Child Support | | | | | | | | | | | |
|  | * Unemployment documentation | | | | | | |  | * Other, specify: | |  | | | | | | | | | |
|  | Documentation of no income: | |  | | | | | | | |  | | | | | | | | | |

**Staff Income Verification signature (required):**

**I have examined the income documents checked above and verify 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: |  | |

I have examined the income documents checked above and certify that the child is eligible to participate in the Head Start/Early Head Start Program.

Staff Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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