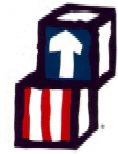
# 0 – 5 YEARS OLD



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:**

| Requirement | Documents |
|---|---|
| **Proof of Age:**<br>• **EHS** - Pregnant women can be any age. Children: Birth to age 3 years after September 1, 2018.<br>• **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. | • Birth Certificate<br>• Passport<br>• Signed Hospital Foot Print Certificate<br>• Notarized Affidavit of Age Form<br>• Doctor’s statement (pregnant women) |
| **Proof of parent’s/legal guardian gross income for the past 12 months or the last calendar year (2017).** | • Signed Income Tax 1040<br>• W-2 form(s)<br>• pay stubs<br>• Unemployment Compensation<br>• Written statement from employers on letterhead<br>• Social Security Supplemental Income (SSI) print-out<br>• TANF print-out<br>• Child Support Agency<br>• Income Statement Form |
| **Proof of Parent’s Identification** | • Driver’s license/Passport<br>• State issued picture I.D.<br>• Employer issued I.D./Military I.D.<br>• Homeless Shelter I.D. |
| **Proof of Miami-Dade County Residency** | • Driver’s license<br>• State issued picture I.D. with address listed<br>• Utility Bills (lights, phone, cable, etc.)<br>• Lease/Rental and/or Mortgage Agreement<br>• TANF/SSI/Unemployment Letter |
| **Proof of Disability** | • Individualized Educational Plan (IEP)<br>• 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<br>• Statement from applicant |
| **Proof of Substance Abuse** | • Statement from Treatment Program Staff |
| **Proof of Domestic Violence** | • Statement from Domestic Violence Agency/Staff<br>• 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/Custody-order |
| **Proof of Legal Guardianship/Custody** | • 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.

# Office Use Only
## (Checked upon receipt of Documentation)

Miami-Dade County
Community Action and Human Services Department
**HEAD START/EARLY HEAD START PROGRAM**
**REGISTRATION REQUIREMENTS**

**ALL DOCUMENTS MUST BE CURRENT TO TIME AT SUBMISSION:**

| | | Yes | No |
|---|---|---|---|
| **Proof of Age:**<br>• **EHS** - Pregnant women can be any age. Children: Birth to age 3 years after September 1, 2018.<br>• **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. | • Birth Certificate<br>• Passport<br>• Signed Hospital Foot Print Certificate<br>• Notarized Affidavit of Age Form<br>• Doctor's statement (pregnant women) | | |
| **Proof of parent's/legal guardian gross income for the past 12 months or the last calendar year (2017).** | • Signed Income Tax 1040<br>• W-2 form(s)<br>• pay stubs<br>• Unemployment Compensation<br>• Written statement from employers on letterhead<br>• Social Security Supplemental Income (SSI) print-out<br>• TANF print-out<br>• Child Support Agency<br>• Income Statement Form | | |
| **Proof of Parent's Identification** | • Driver's license/Passport<br>• State issued picture I.D.<br>• Employer issued picture I.D.<br>• Military picture I.D.<br>• Homeless Shelter picture I.D. | | |
| **Proof of Miami-Dade County Residency** | • Driver's license with address listed<br>• State issued picture I.D. with address listed<br>• Utility Bills (lights, phone, cable, etc.)<br>• 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<br>• 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 Care/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** ______________________________

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 |
|---|---|---|---|
| | | | |
| | | | |

**Number in Household** ____ (Living with Child) **Number in Family** ____ (Supported by the income of parent or guardian) **Total Number(s) of Children** ____ **Age(s)** 0-3 ____ **Age(s)** 4-5 ____ **Age(s)** 6 & above ____

**Parental Status:**
- ☐ Biological/Adopted/Stepparent
- ☐ Foster*
- ☐ Legal Guardian*
- ☐ Grandparent*
- ☐ Niece/Nephew*
- ☐ Other, specify*____________________

☐ **One parent** ☐ **Two parents**

*** Legal court documentation is required to enroll child.**

**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, must specify: ______________________

**Center Applying for**:
______________________
______________________

**Family Income:**

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

HS/EHS STAFF USE ONLY

| Income Sources: | Amount: | Frequency: |
|---|---|---|
| | | ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month ☐ Annually |
| | | ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month ☐ Annually |
| | | ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month ☐ 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)? ☐ **Yes** ☐ **No**

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

☐ **If No Doctor*** *STAFF USE ONLY
**(Staff refers parent to a Medical Provider):** Date: Staff Name:

**(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 refers parent to a Dental Provider):** 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: | Proof of age verified: | Source of age verification: |
|---|---|---|---|
| | ☐ M ☐ F | ☐ Yes ☐ No | ☐ 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

**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.**

**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: ____________

### 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)

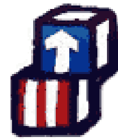
| Place check ☑ in appropriate box | Yes | No |
|---|---|---|
| Documented Substance abuse | | |
| Documented Domestic Violence | | |
| Documented Parent education <8th grade | | |
| Documented Teen Parent <17 years old | | |
| Documented Public Housing Resident (MPHA) | | |
| Documented Working Parent / Student | | |
| Documented Parental Disability | | |
| Returning Sibling(s) in Head Start/Early Head Start | | |
| 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 | | |

| Place check ☑ in appropriate box | | Yes | No |
|---|---|---|---|
| Homelessness: | Length of time homeless: / Agency Name: | | |
| If Yes, explain: | | | |
| ELC-Child Care Subsidy Voucher *(EHS-CCP only)* If **Yes** Date: | | | |
| No apparent Social Service or Special Needs | | | |
| **Notes:** | | | |

****Application Referral Source:** (required)

☐Early Learning Coalition ☐MCI ☐Community Outreach ☐Disability Program ☐Court-Ordered Referral ☐Department of Children & Families ☐Early Head Start ☐Family/Friend ☐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 Agency ☐Youth Fair ☐HS/EHS Flyer
☐ Other (Please, specify):________________________

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** ☐ **Provides Financial Support**

**Language Proficiency:**
**English**
☐ 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
☐ Bi-racial/Multi-racial

**Education:**
☐ 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:**
☐ Is in job training or school
☐ Is **NOT** in job training or school

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

**Secondary Adult (Parent/Legal Guardian):**

| Last | First | Middle | Birthdate | Gender: ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

☐ **Lives with Family** ☐ **Provides Financial Support**

**Language Proficiency**:
**English**
☐ 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
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**Education:**
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☐ High school graduate or GED
☐ 9th – 12th grade
☐ less than 8th grade

**Job Training/School:**
☐ Is in job training or school
☐ Is **NOT** in job training or school

**Ethnicity:**
☐ 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 | |
| ☐Adult ☐Child | | | | ☐ Male ☐ Female | |
| ☐Adult ☐Child | | | | ☐ Male ☐ 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:**

Miami-Dade County
Community Action and Human Services Department
**Head Start / Early Head Start**

## ELIGIBILITY DETERMINATION FORM

(*For Head Start/EHS Staff 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: _________

   **CALCULATION AREA FOR INCOME (IF NEEDED)**
5. Verify Eligibility – Enrollment by Type of Eligibility:
   - ☐ Income below 100% of federal poverty guidelines _____%
   - ☐ *Over-Income* above 100% of federal poverty guidelines _____%
   - ☐ *Homeless
   - ☐ *Foster Care
   - ☐ Supplemental Security Income (SSI) (Public Assistance)
   - ☐ Temporary Assistance to Needy Families (TANF) (Public Assistance)

   **Relevant Time Period used for calculation of income:**
   - ☐ Last Calendar Year _________ ***or***
   - ☐ Previous 12 months ___________________
6. Family Size: **(Supported by the income of the parent(s) or legal guardian-see page 1 of application):** ________
7. Documentation used to determine eligibility for the previous twelve months or last calendar year:

| | |
|---|---|
| ☐ Income Tax Form(s) 1040 | ☐ TANF documentation/Public Assistance |
| ☐ W-2/1099 | ☐ SSI documentation/Public Assistance |
| ☐ Written statements from employer(s) | ☐ *Homeless Shelter documentation |
| ☐ Pay Stub(s) | ☐ *Foster Care documentation |
| ☐ Grants/Scholarships | ☐ Court-ordered Child Support documentation |
| ☐ Unemployment documentation | ☐ Income Statement Form |

Other eligibility documentation: ________________________________

**<u>HS/EHS Staff Eligibility Determination signature</u>** *(required)***:**

Date of in-person interview: _______________ Completed by Staff Name______________________
(Please print)

***Based on my examination and verification of the age and income documents provided by parent or guardian, I have determined that the child is eligible to participate in the HS/EHS program.***

Staff Signature:______________________________________Title:____________________Date:________

Staff name printed:___________________________________Title:______________________________

Administrative Signature:______________________________Title:____________________Date:________