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

FAMILY MEMBER INFORMATION

Child's Name | **Date of Birth** | ☐ Head Start ☐ Early Head Start ☐ EHS-CCP

First	Middle	Last		**Center applying for:**

Primary Adult (Parent/Legal Guardian)

First	Middle	Last	Birthdate	Gender ☐ Male ☐ Female

Race
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Bi-racial/Multi-racial

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

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

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

Employment
☐ **EMPLOYED**
Where? ____________________________
☐ Full-time (35 hours or more)
☐ Part-time (35 hours or fewer)
☐ **UNEMPLOYED/Not working as of:**___________
Are you: ☐ Retired or ☐ Disabled
Are you receiving SSA or SSI? ____________

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

Child's Relationship: ☐ Biological/Adopted/Step ☐ Foster Parent ☐ Grandparent ☐ Other Relative ☐ Legal Guardian ☐ Custody ☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent ☐ Subsidized

Is there a current order of protection or no contact order which concerns this child? ☐ Yes ☐ No

Email Address:____@_____________________________

Secondary Adult (Parent/Legal Guardian)

First	Middle	Last	Birthdate	Gender ☐ Male ☐ Female

Race
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Bi-racial/Multi-racial

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

Language Proficiency
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Employment
☐ **EMPLOYED**
Where? ____________________________
☐ Full-time (35 hours or more)
☐ Part-time (35 hours or fewer)
☐ **UNEMPLOYED/Not working as of:** ___________
Are you: ☐ Retired or ☐ Disabled
Are you receiving SSA or SSI? ____________

Job Training/ School
☐ Is in job training or school
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Child's Relationship: ☐ Biological/Adopted/Step ☐ Foster Parent ☐ Grandparent ☐ Other Relative ☐ Legal Guardian ☐ Custody ☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent ☐ Subsidized

Is there a current order of protection or no contact order which concerns this child? ☐ Yes ☐ No

Email Address:____@_____________________________

Current Telephone/Address Information for Parent/Guardian

Living Address:	**City:**	**State:** FL	**Zip Code:**	**County:** Miami-Dade
Mailing Address (if different):	**City:**	**State:**	**Zip Code:**	**County:**

Phone Number(s)	**Home/Work/Cellular**	**Relationship to child**	**Opt-In Text/EMAIL**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

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FAMILY INFORMATION

Child's Name			Date of Birth	☐ Head Start ☐Early Head Start ☐EHS-CCP
First	Middle	Last		**Center applying for:**

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

Parental Status:

☐ One parent ☐ Two parents

**Legal Documentation is required to enroll child.*

Primary Language of Family at Home:
☐ English ☐ Spanish ☐ European Slavic ☐ Creole ☐ African ☐ Pacific Island
☐ East Asian ☐ Middle Eastern & South Asian ☐ Native North American /Alaskan
☐ North/Central American, South American ☐ Other, must specify: ___________________

Eligibility Verification

Homeless: ☐ Yes ☐ No **Active Military:** ☐ Yes ☐ No **Military Veterans:** ☐ Yes ☐ No **Referred by Child Welfare Agency:** ☐Yes ☐No
TANF: ☐ Yes ☐ No ☐ Formerly **SSI:** ☐ Yes ☐ No **Receiving SNAP/Food Stamps:** ☐ Yes ☐ No **WIC:** ☐ Yes ☐ No **WIC ID#:**___________________

Head Start/Early Head Start STAFF USE ONLY

Name of Parent/Legal Guardian	Amount	Frequency	Description	Verification of Income Source
		☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Annually		
		☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Annually		
		☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Annually		

Please specify in the **Verification** column to the left.
Earned Income: 1040, W2, Paystubs, Employer letter, Social Security Pension/Retirement or Disabled, Unemployment Compensation, etc.
Unearned income: Public Assistance (i.e. TANF, SNAP or SSI), Foster Care Court Order, Certification of Zero Income, Court Ordered Child Support or Alimony, etc.

Total Income:

Eligibility Notes:

EMERGENCY CONTACTS:

Name	Relationship	Release to	Address	Phone #
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

FAMILY CIRCUMSTANCES: (please complete carefully)

Place check ☑ in appropriate box		Yes	No	Place check ☑ in appropriate box	Yes	No
Documented Pregnant Woman				Documented –Referred for services by a child welfare agency		
Documented Public Housing Resident (MPHA)				Documented Substance abuse		
Homelessness	Length of time homeless: Agency Name:			Displaced families due to disasters		
Documented Domestic Violence				Documented Parental Disability		
Returning Sibling(s) in Head Start/Early Head Start				Documented ELC-Child Care Subsidy (***EHS-CCP only)***		

Application Referral Source:

☐ Early Learning Coalition ☐ MCI ☐ Community Outreach ☐ Early Steps/FDLRS ☐ Court-Ordered Referral ☐ Self-Referral
☐ Department of Children & Families ☐ Early Head Start ☐ Family/Friend ☐ Former Parent ☐ Hospital/Health Clinic ☐ Hotline
☐ Healthy Start ☐ Public Housing ☐ Public or Private Non-Profit Organization ☐ Public Schools ☐ WIC
☐ Resource & Referral Agency ☐ CareerSource ☐ Unemployment Agency ☐ HS/EHS Flyer ☐ Flyer on Bus/Train/Billboard
☐ Social Media (FB, Twitter, Instagram, TikTok, etc…) ☐ CVAC Program
☐ Other (Please, specify):______________________________________

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CHILD INFORMATION

First	Middle	Last Name	Nickname	Suffix	☐ Head Start ☐ Early Head Start ☐ EHS-CCP
					Center applying for:
Birthdate:	**Gender:** ☐ M ☐ F	**Was this child born premature?** ☐ Yes ☐ No # of Weeks Premature ________	**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/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 Health Coverage:
☐ Children Health Insurance Program (CHIP)
☐ Combined Medicaid/CHIP
☐ Medicaid
☐ No Insurance
☐ Other
☐ Private Health Insurance
☐ State–only funded Insurance

Other Health Coverage:
☐ Children Health Insurance Program (CHIP)
☐ Combined Medicaid/CHIP
☐ Medicaid
☐ No Insurance
☐ Other
☐ Private Health Insurance
☐ State–only funded Insurance

Health Insurance Name:
____

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

Medicaid Number:______________________

Health Coverage:
Health Insurance #:______________________
Doctor/Medical Home (Pediatrician's Name):
____

Dental Coverage:
Dental Insurance Name: ______________________
Dental Insurance #:______________________
Dentist/Dental Home (Dentist's Name):
____

Health Services

Assistive Devices Used: ☐ N/A ☐ PE Tubes ☐ Glasses ☐ Contact Lenses ☐ Crutches ☐ Walker ☐ Cane ☐ Wheelchair ☐ Braces ☐ Hearing Aides
Receiving Medical Insurance: ☐ Yes ☐ No **Receiving Dental Insurance:** ☐ Yes ☐ No

Does your child receive medical treatment for: ☐ N/A ☐ Anemia ☐ Asthma ☐ Diabetes ☐ High Lead Level ☐ **Other, please *describe below*:**

List all known allergies, dietary needs, or other medical/dental areas of concern: ☐ None known **Describe concerns:**

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:**
Do you have any concerns regarding your child's behavior or development?	☐ No ☐ Yes	**If YES, please explain:**

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	

Verification (Signature required) PLEASE READ BEFORE SIGNING

I verify that the information provided in this application package, (including the proof of age and income provided for eligibility determination) is true and correct to the best of my knowledge and that all parent's/legal Guardian's income are reported.

Print Parent/Legal Guardian Name:	Parent/ Legal Guardian Signature:	Date

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ELIGIBILITY DETERMINATION FORM

1. Primary Adult Name: ______________________________ Birthdate: ______________

2. Eligible Child Name: ______________________________ Birthdate: ______________

3. Earned Income Amount:____________Unearned Income Amount:__________Total: ______________

CALCULATION AREA FOR INCOME (IF NEEDED)

4. **Verifying** 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)
   - ☐ Supplemental Nutrition Assistance Program (SNAP) (Public Assistance)

***Relevant Time Period* used for calculation of income:**

☐ Last Calendar Year______________ ***or***

☐ Previous 12 months _

5. **Family Size:** *(Supported by the income of the parent(s) or legal guardian-see page 1 of application):* __________

6. **Documentation** used to determine eligibility for the Relevant Time Period:

☐ Income Tax Form(s) 1040, 1099	☐ TANF documentation/Public Assistance
☐ W-2	☐ SSI documentation/Public Assistance
☐ Social Security Administration (SSA)	☐ SNAP documentation/Public Assistance
☐ Written statements from employer(s)	☐ Homeless documentation
☐ Pay Stub(s)	☐ Foster Care documentation
☐ Unemployment documentation	☐ Income Statement Form
☐ Court-ordered Child Support documentation	☐ Certification of Zero Income Form

☐ Other eligibility related documentation: ______________________________

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

Date of in-person/phone/virtual interview:_______________Completed by Staff Name: ________________
(Please print)

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

Staff Name (print):______________________________Title: ______________________________

Staff signature: ______________________________ Date: ________________

Administrative Signature:__________________________Title:________________Date: ___________