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

0 – 5 YEARS OLD
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 submission. 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: • **EHS** - Pregnant women can be any age. Children: Birth to age 36 months after September 1, 2020. • **HS** - Children **must** be at least 3 years old on or before September 1, 2020, or no more than five (5) years old after September 1, 2020.	• Birth Certificate • Passport • Signed Hospital Foot Print Certificate • Notarized Affidavit of Age Form • Doctor's statement (pregnant women)
Proof of parent/legal guardian gross income for the past 12 months or the last calendar year (2019).	• 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/legal guardian Identification	• 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	• 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	• Statement from homeless facility or social worker • Self-reported Statement from Parent/guardian
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 ELC-Child Care Subsidy *(EHS-CCP only)*	• ELC-Child Care Subsidy Voucher (with dates of eligibility)
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	• Doctor's statement with expected date of delivery
Proof of Public Housing Residency	• MDPHA Rental/Lease Agreement
Proof of Foster Care-Legal Custody	• Documentation from Foster Care Agency/Court 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.

Miami-Dade County
Community Action and Human Services Department

Head Start/Early Head Start Program

APPLICATION

Office Use Only

(Checked upon receipt of Documentation)

REGISTRATION REQUIREMENTS

ALL DOCUMENTS MUST BE CURRENT AT TIME AT SUBMISSION:

		Yes	No
Proof of Age: • **EHS** - Pregnant women can be any age. Children: Birth to age 3 years after September 1, 2020. • **HS** - Children **must** be at least 3 years old on or before September 1, 2020, or no more than five (5) years old after September 1, 2020.	• Birth Certificate • Passport • Signed Hospital Foot Print Certificate • Notarized Affidavit of Age Form • Doctor's statement (pregnant women)		
Proof of parent/legal guardian gross income for the past 12 months or the last calendar year (2019).	• 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/legal guardian Identification	• Driver's license/Passport • State issued picture I.D. • Employer issued picture I.D. • Military picture I.D. • Homeless Shelter picture I.D.		
Proof of Miami-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 ELC-Child Care Subsidy *(EHS-CCP only)*	• ELC-Child Care Subsidy Voucher (w/ dates of eligibility)		
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 Order		
Proof of Guardianship/Legal Custody	• Documentation from Court System/Custody Court Order		

Parents must 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 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	Ethnicity	Language Proficiency
☐ Asian ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Bi-racial/Multi-racial	☐ Hispanic or Latino Origin ☐ Non-Hispanic or Latino Origin **Nationality**:_____	**English** ☐ None ☐ Poor ☐ Moderate ☐ Proficient **Other Language Spoken**:_____ ☐ None ☐ Poor ☐ Moderate ☐ Proficient

Education	Employment	Job Training/School
☐ 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	☐ **EMPLOYED** Where? _____ ☐ Full-time (35 hours or more) ☐ Part-time (35 hours or fewer) ☐ **UNEMPLOYED/Not working:** _____ Are you: ☐ Retired or ☐ Disabled Are you receiving SSA or SSI? _____	☐ 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	Ethnicity	Language Proficiency
☐ Asian ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Bi-racial/Multi-racial	☐ Hispanic or Latino Origin ☐ Non-Hispanic or Latino Origin **Nationality**:_____	**English** ☐ None ☐ Poor ☐ Moderate ☐ Proficient **Other Language Spoken**:_____ ☐ None ☐ Poor ☐ Moderate ☐ Proficient

Education	Employment	Job Training/ School
☐ 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	☐ **EMPLOYED** Where? _____ ☐ Full-time (35 hours or more) ☐ Part-time (35 hours or fewer) ☐ **UNEMPLOYED/Not working:** _____ Are you: ☐ Retired or ☐ Disabled Are you receiving SSA or SSI? _____	☐ 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: _____@_____

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
			☐ Yes ☐ No
			☐ Yes ☐ No

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

FAMILY INFORMATION

Child's Name			**Date of Birth**	☐**Head Start** ☐**Early Head Start** ☐**EHS-CCP**	
First	Middle	Last		**Center applying for:**	
Number in Household	**Number in Family** (Supported by the income of parent or guardian)	**Total Number of Children**	**Age(s)** 0-3	**Age(s)** 4-5	**Age(s)** 6 & 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

Eligibility Verified by: **Eligibility Verification Date:**

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 or SSI), Foster Care Court Order/Reimbursement, Certification of Zero income, Court Ordered Child Support/ 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:			Displaced families due to disasters		
	Agency Name:					
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 ☐ Youth Fair ☐ WIC
☐ Resource & Referral Agency ☐ CareerSource ☐ Unemployment Agency ☐ HS/EHS Flyer ☐ Flyer on Bus/Train/Billboard
☐ Other (Please, specify):_____

Miami-Dade County
Community Action and Human Services Department

Head Start/Early Head Start Program

APPLICATION

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
Continuous Medical Care: ☐ Yes ☐ No **Continuous Dental Care:** ☐ 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 concerns: ☐ 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 accurate and truthful to the best of my knowledge. I understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate or untruthful information could result in the disenrollment of my child from the Head Start/ Early Head Start/ Early Head Start Child Care Partnership Program and could have serious legal consequences for me.

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

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

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 Amount: _____ Unearned Income Amount: _____ Total: _____

CALCULATION AREA FOR INCOME (IF NEEDED)

5. **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)

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 Relevant Time Period:

- ☐ Income Tax Form(s) 1040
- ☐ W-2/1099
- ☐ Written statements from employer(s)
- ☐ Pay Stub(s)
- ☐ Unemployment documentation
- ☐ Court-ordered Child Support documentation
- ☐ TANF documentation/Public Assistance
- ☐ SSI documentation/Public Assistance
- ☐ *Homeless Shelter documentation
- ☐ *Foster Care documentation
- ☐ Income Statement Form
- ☐ Certification of Zero Income Form
- ☐ Other eligibility documentation: _____

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

Date of in-person 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 Signature:_____Title:_____ Date: _____

Staff name (print):_____ Date: _____

Administrative Signature:_____ Title:_____ Date: _____