



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, 2014. HS- Children must be 3 or 4 years of age on or before September 1, 2014, or no more than five (5) years old after September 1, 2014.	<ul style="list-style-type: none"> <li>• Birth Certificate</li> <li>• Passport</li> <li>• Notarized Affidavit of Age Form</li> <li>• Doctor’s statement (pregnant women)</li> </ul>
<b>Proof of parent’s/legal guardian gross income for the past 12 months or the last calendar year (2013).</b>	<ul style="list-style-type: none"> <li>• Signed Income Form Tax 1040 (with eligible child name listed)</li> <li>• W-2 forms</li> <li>• pay stubs</li> <li>• Unemployment Compensation</li> <li>• Written statement from employers</li> <li>• Social Security Supplemental Income (SSI) printout</li> <li>• TANF print out</li> <li>• Child Support</li> <li>• Income Statement</li> </ul>
<b>Proof of Parent’s Identification</b>	<ul style="list-style-type: none"> <li>• Driver’s license/Passport</li> <li>• State issued picture I.D.</li> <li>• Employer issued I.D./Military ID</li> <li>• Homeless Shelter ID</li> </ul>
<b>Proof of Dade County Residency</b>	<ul style="list-style-type: none"> <li>• Driver’s license</li> <li>• State issued picture I.D. with address listed</li> <li>• Utility Bills (lights, phone, cable, etc)</li> <li>• Lease/Rental and Mortgage Agreement</li> <li>• TANF/SSI/Unemployment Letter</li> </ul>
<b>Proof of Disability</b>	<ul style="list-style-type: none"> <li>• Individualized Educational Plan (IEP)</li> <li>• Individualized Family Support Plan IFSP</li> </ul>
<b>Proof of Suspected Disability</b>	<ul style="list-style-type: none"> <li>• Doctor/Therapist evaluations and statements outlining concerns</li> </ul>
<b>Proof of Homelessness Verification</b>	<ul style="list-style-type: none"> <li>• Statement from homeless facility or social worker</li> <li>• Statement from applicant</li> </ul>
<b>Proof of Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Statement from Treatment Program Staff</li> </ul>
<b>Proof of Domestic Violence</b>	<ul style="list-style-type: none"> <li>• Statement from Domestic Violence Agency/Staff</li> <li>• Court Documentation (within the last year)</li> </ul>
<b>Proof of Student Status</b>	<ul style="list-style-type: none"> <li>• Current Transcript</li> </ul>
<b>Proof of Education Eight Grade and Below</b>	<ul style="list-style-type: none"> <li>• Statement from Applicant/Official School Transcript</li> </ul>
<b>Proof of Parental Disability</b>	<ul style="list-style-type: none"> <li>• SSI Recipient Letter/Doctor’s Statement</li> </ul>
<b>Proof of Pregnancy</b>	<ul style="list-style-type: none"> <li>• Medical Documentation (current)</li> </ul>
<b>Proof of Public Housing Residency</b>	<ul style="list-style-type: none"> <li>• MDPHA Rental/Lease Agreement</li> </ul>
<b>Proof of Foster Care-Legal Custody</b>	<ul style="list-style-type: none"> <li>• Documentation from Foster Care Agency/Court Award</li> </ul>
<b>Proof of Legal Guardianship/Custody</b>	<ul style="list-style-type: none"> <li>• Documentation from the Court System/Court Award</li> </ul>

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)



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<b>Proof of Age :</b> EHS- Birth to age 3 years after September 1, 2014. HS -Children must be 3 or 4 years of age on or before September 1, 2014, or no more than five (5) years old after September 1, 2014)	<ul style="list-style-type: none"> <li>• Birth Certificate</li> <li>• Passport</li> <li>• Notarized Affidavit of Age</li> <li>• Doctor’s statement (pregnant women)</li> </ul>		
<b>Proof of parent’s/legal guardian gross income for the <u>past 12 months or the last calendar year (2013).</u></b>	<ul style="list-style-type: none"> <li>• Signed Income Form Tax 1040 with eligible child name listed</li> <li>• W-2 forms</li> <li>• pay stubs (proof for the last 12 months)</li> <li>• Unemployment Compensation</li> <li>• Written statements from employers(letterhead)</li> <li>• Social Security Supplemental Income (SSI/TANF) printouts</li> <li>• Child Support Agency</li> <li>• Notarized Income Statement</li> </ul>		
<b>Proof of Parent’s Identification</b>	<ul style="list-style-type: none"> <li>• Driver’s license/Passport/ID from Homeless Shelter</li> <li>• State issued picture I.D.</li> <li>• Employer issued I.D.</li> <li>• Military ID</li> </ul>		
<b>Proof of Dade County Residency</b>	<ul style="list-style-type: none"> <li>• Driver’s license with address listed</li> <li>• State issued picture I.D. with address listed</li> <li>• Utility Bills (lights, phone, cable, etc)</li> <li>• Lease Rental /Mortgage Agreement</li> </ul>		
<b>Proof of Disability</b>	<ul style="list-style-type: none"> <li>• Individualized Educational Plan (IEP) /IFSP</li> </ul>		
<b>Proof of Suspected Disability</b>	<ul style="list-style-type: none"> <li>• Doctor’s Statement outlining concerns</li> </ul>		
<b>Proof of Homelessness</b>	<ul style="list-style-type: none"> <li>• Written Statement from Homeless Facility</li> </ul>		
<b>Proof of Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Written Statement from Treatment Program</li> </ul>		
<b>Proof of Domestic Violence</b>	<ul style="list-style-type: none"> <li>• Written Statement from Domestic Violence Agency</li> <li>• Court Documentation (within the last year)</li> </ul>		
<b>Proof of Student Status</b>	<ul style="list-style-type: none"> <li>• Current transcript</li> </ul>		
<b>Proof of Education eight grade and below</b>	<ul style="list-style-type: none"> <li>• Written Statement from applicant/School Transcript</li> </ul>		
<b>Proof of Parental Disability</b>	<ul style="list-style-type: none"> <li>• Written SSI recipient letter/Doctor’s statement</li> </ul>		
<b>Proof of Pregnancy</b>	<ul style="list-style-type: none"> <li>• Written Medical Documentation (current)</li> </ul>		
<b>Proof of Public Housing Residency</b>	<ul style="list-style-type: none"> <li>• MDPHA Written Rental/Lease Agreement</li> </ul>		
<b>Proof of Foster Caret/Legal Custody</b>	<ul style="list-style-type: none"> <li>• Documentation from Foster Care Agency/ Court Award</li> </ul>		
<b>Proof of Guardianship/Legal Custody</b>	<ul style="list-style-type: none"> <li>• Documentation from Court System/ Court Award</li> </ul>		

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
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	

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

Parental Status:  Natural/Adopted/Stepparent  Foster  
 Grandparent  Niece/Nephew  
 One parent  Two parents

Primary Language at Home: \_\_\_\_\_

Center Applying for: \_\_\_\_\_

**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)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Agricultural Earned Income (i.e. wages, tips)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Public Assistance, Welfare (i.e. TANF, AFDC)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Social Security Pension / Retirement	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Supplemental Security Insurance (SSI)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Foster Care/Adoption Subsidy	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Unemployment Compensation	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Child Support/Alimony	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
Other Unearned Income	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> 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  
Eligible Child Information**



**Eligible Child (New Enrollee):**

Last		First		Middle		Preferred / Nickname		Suffix	
Birthday		Gender <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Proof of age verified		Source of age verification:			
<b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White  <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin  Nationality: _____		<b>English Proficiency:</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<b>Medicaid Eligibility:</b> <input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible  Medicaid Number: _____		<b>Health Insurance Information:</b> Name//Number: _____  <input type="checkbox"/> Other/Private Health Coverage(list name of provider): _____  <input type="checkbox"/> No Health insurance Coverage Referral completed to: _____  Kidcare Application Completed Date: _____ Staff: _____ Date: _____			
		<b>Other Language Spoken:</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient							
		<b>Primary Adult Relationship to Child:</b> <input type="checkbox"/> Custody <input type="checkbox"/> Foster* <input type="checkbox"/> Grandchild* <input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step <input type="checkbox"/> Niece* <input type="checkbox"/> Nephew* <input type="checkbox"/> Other* (specify) _____  <b>Secondary Adult Relationship to Child:</b> <input type="checkbox"/> Custody <input type="checkbox"/> Foster* <input type="checkbox"/> Grandchild* <input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step <input type="checkbox"/> Niece* <input type="checkbox"/> Nephew* <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							

**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:	Yes	No	Parental Status:	Yes	No
Place check <input checked="" type="checkbox"/> in appropriate box			Place check <input checked="" type="checkbox"/> in appropriate box		
Documented Substance abuse			One Parent		
Documented Domestic Violence			Two Parents		
Documented Parent education <8 <sup>th</sup> grade			Foster Parent		
Documented Teen Parent <17 years old			Legal Guardian		
Homeless Length of time homeless: _____ Agency: _____			<b>Family Services:</b> Place check <input checked="" type="checkbox"/> 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 Member Information**



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

Last	First	Middle	Birthday	Gender
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- Lives with Family       Custody       Provides Financial Support       Teen Parent

<b>Employment Status:</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> US Military <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed  <b>English Proficiency:</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <b>Other Language Spoken:</b> _____ <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White  <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin	<b>Education:</b> <input type="checkbox"/> Associates <input type="checkbox"/> Bachelors <input type="checkbox"/> Masters  <input type="checkbox"/> College Degree/Training  <input type="checkbox"/> College Degree or advance Training  <input type="checkbox"/> 9 <sup>th</sup> grade or less <input type="checkbox"/> 10 <sup>th</sup> grade <input type="checkbox"/> 11 <sup>th</sup> grade <input type="checkbox"/> 12 <sup>th</sup> Grade <input type="checkbox"/> High School
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**Secondary Adult (Parent/Legal Guardian):**

Last	First	Middle	Birthday	Gender
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- Lives with Family       Custody       Provides Financial Support       Teen Parent

<b>Employment Status:</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> US Military <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed  <b>English Proficiency:</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <b>Other Language Spoken:</b> _____ <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White  <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin	<b>Education:</b> <input type="checkbox"/> Associates <input type="checkbox"/> Bachelors <input type="checkbox"/> Masters  <input type="checkbox"/> College Degree/Training  <input type="checkbox"/> College Degree or advance Training  <input type="checkbox"/> GED <input type="checkbox"/> 9 <sup>th</sup> grade or less <input type="checkbox"/> 10 <sup>th</sup> grade <input type="checkbox"/> 11 <sup>th</sup> grade <input type="checkbox"/> 12 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> grade or less <input type="checkbox"/> High School
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**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  
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: \_\_\_\_\_ 1<sup>st</sup> Year Child's date of entry into program: \_\_\_\_\_  
2<sup>nd</sup> Year Child's date of entry into program: \_\_\_\_\_ 3<sup>rd</sup> 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:
 

<input type="checkbox"/> Income Tax Form 1040 (last calendar year)	<input type="checkbox"/> Written statements from employers
<input type="checkbox"/> Public Aid / TANF-documentation	<input type="checkbox"/> Foster care reimbursement
<input type="checkbox"/> Pay stubs	<input type="checkbox"/> SSI documentation
<input type="checkbox"/> W-2 (last calendar year)	<input type="checkbox"/> Social Security(last calendar year/12 months)
<input type="checkbox"/> Grants/Scholarships/Financial Aid	<input type="checkbox"/> Child Support
<input type="checkbox"/> Unemployment	<input type="checkbox"/> 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: \_\_\_\_\_