



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 THE TIME OF SUBMISSION:

<p>Proof of Age:</p> <ul style="list-style-type: none"> • EHS - Pregnant women can be any age. Children: Infants and toddlers under 36 months. • HS - Children must be already 3 years old or 3 years old by September 1. 	<ul style="list-style-type: none"> • Birth Certificate • Passport • Signed Hospital Foot Print Certificate • Notarized Affidavit of Age Form • Doctor's statement (pregnant women) • Other related proof of birth document
<p>Proof of parent/legal guardian gross income for the past 12 months or the last calendar year.</p> <p>PUBLIC ASSISTANCE:</p> <ul style="list-style-type: none"> • Supplemental Security Income (SSI) or • TANF (Cash Assistance) print-outs or • SNAP Benefits (Food Stamps) Letter. 	<ul style="list-style-type: none"> • Income Tax Forms (1040, W-2, or 1099, etc...) • Pay stubs • Unemployment Compensation • Written statement from employers on letterhead • Child Support Agency
<p>Proof of parent/legal guardian Identification</p>	<ul style="list-style-type: none"> • Driver's license/Passport • State issued picture I.D. • Employer issued I.D./Military I.D. • Homeless Shelter I.D.
<p>Proof of Miami-Dade County Residency</p>	<ul style="list-style-type: none"> • 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
<p>Proof of Disability</p>	<ul style="list-style-type: none"> • Individualized Educational Plan (IEP) • Individualized Family Support Plan (IFSP)
<p>Proof of Suspected Disability</p>	<ul style="list-style-type: none"> • Doctor/Therapist evaluations and statements outlining concerns
<p>Proof of Homelessness</p>	<ul style="list-style-type: none"> • Statement from homeless facility or social worker • Self-reported Statement from Parent/guardian
<p>Proof of Substance Abuse</p>	<ul style="list-style-type: none"> • Statement from Treatment Program Staff
<p>Proof of Domestic Violence</p>	<ul style="list-style-type: none"> • Statement from Domestic Violence Agency/Staff • Court Documentation (within the last year)
<p>Proof of ELC-Child Care Subsidy (EHS-CCP only)</p>	<ul style="list-style-type: none"> • ELC-Child Care Subsidy Voucher (with dates of eligibility)
<p>Proof of Student Status</p>	<ul style="list-style-type: none"> • Current Transcript/Class Schedule
<p>Proof of Education Eight Grade and Below</p>	<ul style="list-style-type: none"> • Statement from Applicant/Official School Transcript
<p>Proof of Parental Disability</p>	<ul style="list-style-type: none"> • SSI Recipient Letter/Doctor's Statement
<p>Proof of Pregnancy</p>	<ul style="list-style-type: none"> • Doctor's statement with expected date of delivery
<p>Proof of Public Housing Residency</p>	<ul style="list-style-type: none"> • MDPHA Rental/Lease Agreement
<p>Proof of Foster Care-Legal Custody</p>	<ul style="list-style-type: none"> • Documentation from Foster Care Agency/Court Order
<p>Proof of Legal Guardianship/Custody</p>	<ul style="list-style-type: none"> • 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. An incomplete application and missing documentation will delay the enrollment



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REGISTRATION REQUIREMENTS

ALL DOCUMENTS MUST BE CURRENT AT TIME OF SUBMISSION:

Office Use Only

		Yes	No
Proof of Age: <ul style="list-style-type: none"> • EHS - Pregnant women can be any age. Children: two months to 36 months. • HS - Children must be at least 3 years old or 3 years old by September 1. 	<ul style="list-style-type: none"> • Birth Certificate • Passport • Signed Hospital Foot Print Certificate • Notarized Affidavit of Age Form • Doctor's statement (pregnant women) • Other related proof of birth document 		
Proof of parent/legal guardian gross income for the past 12 months or the last calendar year. <ul style="list-style-type: none"> • Public Assistance Benefits • (SSI), • (SNAP) and • (TANF) print-outs 	<ul style="list-style-type: none"> • Income Tax Form (1040, W-2, or 1099, etc...) • Pay stubs • Unemployment Compensation • Written statement from employers on letterhead • Child Support Agency 		
Proof of parent/legal guardian Identification	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Individualized Educational Plan (IEP) /IFSP 		
Proof of Suspected Disability	<ul style="list-style-type: none"> • Doctor's Statement outlining concerns 		
Proof of Homelessness	<ul style="list-style-type: none"> • Written Statement from Homeless Facility 		
Proof of Substance Abuse	<ul style="list-style-type: none"> • Written Statement from Treatment Program 		
Proof of Domestic Violence	<ul style="list-style-type: none"> • Written Statement from Domestic Violence Agency • Court Documentation (within the last year) 		
Proof of ELC-Child Care Subsidy (EHS-CCP only)	<ul style="list-style-type: none"> • ELC-Child Care Subsidy Voucher (w/ dates of eligibility) 		
Proof of Student Status	<ul style="list-style-type: none"> • Current transcript 		
Proof of Education eight grade and below	<ul style="list-style-type: none"> • Written Statement from applicant/School Transcript 		
Proof of Parental Disability	<ul style="list-style-type: none"> • Written SSI recipient letter/Doctor's statement 		
Proof of Pregnancy	<ul style="list-style-type: none"> • Written Medical Documentation (current) 		
Proof of Public Housing Residency	<ul style="list-style-type: none"> • MDPHA Written Rental/Lease Agreement 		
Proof of Foster Care/Legal Custody	<ul style="list-style-type: none"> • Documentation from Foster Care Agency/Court Order 		
Proof of Guardianship/Legal Custody	<ul style="list-style-type: none"> • 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. 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 _____



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FAMILY MEMBER INFORMATION

Child's Name					Date of Birth	<input type="checkbox"/> Head Start <input type="checkbox"/> Early Head Start <input type="checkbox"/> EHS-CCP	
First	Middle	Last			Center applying for:		
Primary Adult (Parent/Legal Guardian)							
First	Middle	Last	Birthdate	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Race		Ethnicity			Language Proficiency		
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi-racial/Multi-racial		<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin Nationality: _____			English <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: _____ <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		
Education		Employment			Job Training/School		
<input type="checkbox"/> An advanced degree or baccalaureate degree <input type="checkbox"/> An associate degree, vocational school, or some college <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> 9 th – 12 th grade <input type="checkbox"/> Less than 8 th grade		<input type="checkbox"/> EMPLOYED Where? _____ <input type="checkbox"/> Full-time (35 hours or more) <input type="checkbox"/> Part-time (35 hours or fewer) <input type="checkbox"/> UNEMPLOYED/Not working as of: _____ Are you: <input type="checkbox"/> Retired or <input type="checkbox"/> Disabled Are you receiving SSA or SSI? _____			<input type="checkbox"/> Is in job training or school <input type="checkbox"/> Is NOT in job training or school		
Child's Relationship: <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Custody <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent <input type="checkbox"/> Subsidized Is there a current order of protection or no contact order which concerns this child? <input type="checkbox"/> Yes <input type="checkbox"/> No Email Address: _____@_____							
Secondary Adult (Parent/Legal Guardian)							
First	Middle	Last	Birthdate	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Race		Ethnicity			Language Proficiency		
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi-racial/Multi-racial		<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin Nationality: _____			English <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: _____ <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		
Education		Employment			Job Training/ School		
<input type="checkbox"/> An advanced degree or baccalaureate degree <input type="checkbox"/> An associate degree, vocational school, or some college <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> 9 th – 12 th grade <input type="checkbox"/> Less than 8 th grade		<input type="checkbox"/> EMPLOYED Where? _____ <input type="checkbox"/> Full-time (35 hours or more) <input type="checkbox"/> Part-time (35 hours or fewer) <input type="checkbox"/> UNEMPLOYED/Not working as of: _____ Are you: <input type="checkbox"/> Retired or <input type="checkbox"/> Disabled Are you receiving SSA or SSI? _____			<input type="checkbox"/> Is in job training or school <input type="checkbox"/> Is NOT in job training or school		
Child's Relationship: <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Custody <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent <input type="checkbox"/> Subsidized Is there a current order of protection or no contact order which concerns this child? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	



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FAMILY INFORMATION

Child's Name			Date of Birth	<input type="checkbox"/> Head Start <input type="checkbox"/> Early Head Start <input type="checkbox"/> EHS-CCP	
First	Middle	Last		Center applying for:	
Number in Family (Supported by the income of the parent or guardian)	Number in Family:	Total Number of Children:	Age(s) 0-3:	Age(s) 4-5:	Age(s) 5 & above:
Parental Status: <input type="checkbox"/> One parent <input type="checkbox"/> Two parents <i>*Legal Documentation is required to enroll child.</i>		Primary Language of Family at Home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> European Slavic <input type="checkbox"/> Creole <input type="checkbox"/> African <input type="checkbox"/> Pacific Island <input type="checkbox"/> East Asian <input type="checkbox"/> Middle Eastern & South Asian <input type="checkbox"/> Native North American /Alaskan <input type="checkbox"/> North/Central American, South American <input type="checkbox"/> 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
		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		
		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		
		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> 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 #
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY CIRCUMSTANCES: (please complete carefully)

Place check <input checked="" type="checkbox"/> in appropriate box	Yes	No	Place check <input checked="" type="checkbox"/> 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:	<input type="checkbox"/> Early Learning Coalition <input type="checkbox"/> MCI <input type="checkbox"/> Community Outreach <input type="checkbox"/> Early Steps/FDLRS <input type="checkbox"/> Court-Ordered Referral <input type="checkbox"/> Self-Referral <input type="checkbox"/> Department of Children & Families <input type="checkbox"/> Early Head Start <input type="checkbox"/> Family/Friend <input type="checkbox"/> Former Parent <input type="checkbox"/> Hospital/Health Clinic <input type="checkbox"/> Hotline <input type="checkbox"/> Healthy Start <input type="checkbox"/> Public Housing <input type="checkbox"/> Public or Private Non-Profit Organization <input type="checkbox"/> Public Schools <input type="checkbox"/> WIC <input type="checkbox"/> Resource & Referral Agency <input type="checkbox"/> CareerSource <input type="checkbox"/> Unemployment Agency <input type="checkbox"/> HS/EHS Flyer <input type="checkbox"/> Flyer on Bus/Train/Billboard <input type="checkbox"/> Social Media (FB, Twitter, Instagram, TikTok, etc...) <input type="checkbox"/> CVAC Program <input type="checkbox"/> Other (Please, specify): _____
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CHILD INFORMATION					
First	Middle	Last Name	Nickname	Suffix	<input type="checkbox"/> Head Start <input type="checkbox"/> Early Head Start <input type="checkbox"/> EHS-CCP
				Center applying for:	
Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Was this child born premature? <input type="checkbox"/> Yes <input type="checkbox"/> No # of Weeks Premature _____	Source of age verification: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Doctor Statement (Pregnant Woman) <input type="checkbox"/> Notarized Affidavit of Age <input type="checkbox"/> Other (Specify):		
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi-racial/Multi-racial Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin Nationality: _____ English Proficiency: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient Other Language Spoken: <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Primary Health Coverage: <input type="checkbox"/> Children Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Other <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> State-only funded Insurance Other Health Coverage: <input type="checkbox"/> Children Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Other <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> State-only funded Insurance Health Insurance Name: _____		Medicaid Eligibility Status: <input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> 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: <input type="checkbox"/> N/A <input type="checkbox"/> PE Tubes <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Hearing Aides Receiving Medical Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Receiving Dental Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does your child receive medical treatment for: <input type="checkbox"/> N/A <input type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> High Lead Level <input type="checkbox"/> Other, please describe below:					
List all known allergies, dietary needs, or other medical/dental areas of concern: <input type="checkbox"/> None known Describe concerns:					
Special Needs/Disability					
Miami-Dade County Public School Diagnosed Disability Evaluation-Individualized Education Plan (IEP):				<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES Date: / /
Early Steps Program-Individualized Family Support Plan (IFSP)			<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, Date:	
Professional Diagnosis (speech therapy, occupational, etc.)			<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, Date:	
Do you have any concerns regarding your child's behavior or development?			<input type="checkbox"/> No <input type="checkbox"/> 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
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Adult <input type="checkbox"/> Child				<input type="checkbox"/> Male <input type="checkbox"/> 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:

- | | |
|-------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Income Tax Form(s) 1040, 1099 | <input type="checkbox"/> TANF documentation/Public Assistance |
| <input type="checkbox"/> W-2 | <input type="checkbox"/> SSI documentation/Public Assistance |
| <input type="checkbox"/> Social Security Administration (SSA) | <input type="checkbox"/> SNAP documentation/Public Assistance |
| <input type="checkbox"/> Written statements from employer(s) | <input type="checkbox"/> Homeless documentation |
| <input type="checkbox"/> Pay Stub(s) | <input type="checkbox"/> Foster Care documentation |
| <input type="checkbox"/> Unemployment documentation | <input type="checkbox"/> Income Statement Form |
| <input type="checkbox"/> Court-ordered Child Support documentation | <input type="checkbox"/> Certification of Zero Income Form |
| <input type="checkbox"/> Other eligibility related documentation: _____ | |

Determining Eligibility - HS/EHS Staff signature (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: _____