HEAD START PROGRAM

Completed application and required documents must be returned to the school. In order to qualify for this program, families must meet the Federal Poverty income guidelines. School based programs offer slots to qualifying three and four year olds. Parents do not have to be employed in order to apply.

Aplicaciones completas y documentos requeridos deben ser devueltos a la escuela. Para poder calificar para el programa, las Familias deben satisfacer los Requisitos de Ingresos de Pobresa Federales. Los Programas basados en la escuela ofrecen espacio para niños de tres y cuatro años. Los Padres no necesitan estar empleados para aplicar.

Documents Needed:

- 1. **Birth Certificate** (child must be 4 years old or 3 years old on or before September 1st of the school year at school sites.
 - **Certificado de Nacimiento** (el nino(a) debe tener 4 o 3 anos antes del 1 de Septiembre de este curso escolar)
- 2. Social Security Card (if available)

 Tarjeta de Seguro Social (si tiene una)
- Proof of family income (last four check stubs; 1040 Tax Form; LES; or letter from employer).
 Prueba de sus ingresos financieros (ultimos 4 cheques de pago, la forma 1040 de los Taxes, o una carta de su empleador)
- Picture I.D. (parent or guardian).
 Identificacion con fotografia (de los padres o guardianes)
- Proof of Food Stamps, WIC , Subsidized Child Care (if applicable)
 Prueba de Sellos de Alimento, WIC, Cuidado Infantil Subvencionado (si aplica)
- Child's Medical & Dental Health Insurance Card (if child has insurance)
 Tarjeta de Seguro Medico y Dental del Niño (si el niño (a) tiene seguro)

If you need more information, please call the numbers listed below; Si usted necesita más información, por favor llame los números enumerados abajo.

Please do not drop off application at the front office (Favor de no dejar las aplicaciones el la oficina principal). Call to schedule an appointment to return the attached forms and completed application. (Favor de llamar a fijar una cita para devolver los formularios adjuntos y aplicación).

Horace O' Bryant please call 305-296-5628 Elizabeth Alvarez x65392 Gerald Adams please call 305-293-1609 Latrice Pla x51329 or Kechena Fleuridor x51378 Stanley Switkley please call Isabel Vargas at 305-289-2490 x59309 Key Largo School please call Katherine Kight at 305-453-1255 x 57400

Applicant & Family Member Information

Applica	int								
First		Middle	Last	Suffix	Nicknar	me Birt	hday Gend	ler SS	N Alt ID
Race				Hispanic	English Pro	ficiency	Other Language		Other Language Proficiency
☐ Asian		can Indian/Alask		☐ Yes	☐ Little				☐ Little
☐ Black		iian/Pacific Island	der	□ No	□ Moderate	9			☐ Moderate
□ White	☐ Multi-	Racial			□ None				□ None
Other:	1111-0	011	_		☐ Proficient				☐ Proficient
Primary F	Health Cov	erage Other	Coverage	Insurance #		aid Eligibility	/ Medic	aid #	Doctor/Medical Home
						Eligible			
						Medicaid			
Dent	al Coverag	е	Dental Cov	verage #	□ Pote	emany	Dentist/De	ental Home	
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☐ Black		iian/Pacific Island		□ No	□ Moderate	2			☐ Moderate
☐ White	☐ Multi-				□ None				□ None
☐ Other:					☐ Proficient	t			☐ Proficient
	rade Comp	leted	E TOTAL TOTAL STREET	Employment Stat		Child's Re	lationship	Custody	
☐ Associa	The state of the s	☐ Grade 10	□ Full Tir		e & Training		cal/Adopted/Step	□ Yes	☐ Lives with Family
☐ Bachelo		☐ Grade 11	□ Part Ti		ne & Training	☐ Grando		□ No	☐ Provides Financial Support
☐ Col Deg		☐ Grade 12	☐ Seaso			☐ Other R		L 140	☐ Teen Parent
□ Col or A	The state of the s	□ < Grade 9	□Unemp		or Disabled	☐ Foster			
☐ GED		☐ HS Graduat	е			☐ Other			If teen parent, subsidized?
		☐ Master's							☐ Yes ☐ No
Email Add	dress:								
Second	ary or 0	ther Adult							
First		Middle	Last	Suffix	Nicknar	ne Birt	hday Gend	er SS	N Alt ID
Race				Hispanic	English Prof	ficiency	Other Language		Other Language Proficiency
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^{*} If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

This Section for Agency Use Only:

Applicant Name: Birthday Family Information, Income & Contacts **Family Information Family Living Address** City Started Living At Date Address Line 2 Living Address ZIP State **Family Mailing Address** Same as living? Started Mailing Address Address ZIP City State **Using Date** Line 2 ☐ Yes ☐ No Phone Number(s) Type (check one) Note (extension or best time to call) Opt In for Text Messages □ Cell □ Home □ Work □ Other ☐ Yes ☐ No □ Cell □ Home □ Work □ Other ☐ Yes ☐ No □ Cell □ Home □ Work □ Other ☐ Yes ☐ No Parental Status Military Homeless Referred by Child Receiving **Primary Language** Active Duty WIC at Home (check one) Family Military Veteran Welfare Agency SNAP ☐ Yes □Yes ☐ Yes □Yes ☐ Yes ☐ Yes □ One □ No □ No □ No □ No □ No □ Two □ No **Family Income** Income Verified by Verification Date TANF Status SSI ☐ Yes □ No ☐ Yes ☐ Formerly on TANF/Not now □ No Family **Amount** Per (for example: week, Annual Description (for Verification (for example: Note example: SSI, Job, W2, check stub) Member month, year) Amount Child Support) \$ \$ 8 \$ \$ \$ Income Notes **Emergency Contacts** Name Relationship **Emergency Contact** Release To ☐ Yes ☐ No ☐ Yes □ No Contact Address ZIP City State Phone Number 2 Phone Number 3 Phone Number 1 ☐ Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work Relationship **Emergency Contact** Release To Name 2 ☐ Yes □ No ☐ Yes □ No Contact State City Address ZIP Phone Number 2 Phone Number 3 Phone Number 1 ☐ Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work **Emergency Contact** Release To Relationship Name m □ No ☐ Yes □ No ☐ Yes Contact State Address ZIP City Phone Number 3 Phone Number 2 Phone Number 1 □ Cell □ Home □ Work □ Cell □ Home □ Work ☐ Cell ☐ Home ☐ Work Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature

Date

Monroe County Public Schools Head Start Program

<u>Financial Release & Third Party Consent</u> <u>Autorización para solicitar informe sobre sus ingresos</u>

I hereby grant permission for the Head Start Program staff to verify my family income by examining the following documents and or calling a third party:

Por la presente autorizo a cualquier agente acreditado del programa de Head Start a verificar los ingresos de mi familia utilizando los siguiente y/o llamar una tercer persona:

		Individual Income Tax Form 1040 for the year Formulario 1040-declaración de ganancias del año
		Pay stubs/ pay envelopes El recibo o comprobante de ganancias/ cheque
		Written statement(s) from employer(s) or family member Declaraciones escrita de empleador o miembros de familia
		Documentation showing current status as recipients of public assistance El recibo mas reciente de asistencia publica
Est	e fo	This form is not valid after the student exits the Head Start Program. rmulario no es válido despues que el estudiante termina con el programa de Head Start.
	Da	te/Fecha
	Ch	ild's Name/Nombre del niño/a
		ent/Guardian mbre de los padres
	Par	ent/Guardian Signature

Firma de los padres

Monroe County Public Schools Head Start Program Additional Family Eligibility Information

List all other family members living in the household whom you First and Last Name	Date of Birth			Sex (M or F)	Relationship to Child
*Please note: If child has a diagnosed disability (IEP or 1	FSP),	docun	ientat	ion relati	ng to the disability must b
along with this application.					8
Special Needs/Disability:	Yes	No	If Y	es Date	
Monroe County School District Individual Education Plan (IEP)					
Early Steps Program- Individualized Family Support Plan					
(IFSP)					
Professional Diagnosis (speech therapy, occupational, etc.):		1.		.44:	ladina da di anno mana
	concer	ns, do	cumen	ntation re	lating to the concern mus
Professional Diagnosis (speech therapy, occupational, etc.): *Please note: If child receives treatment for any medical opposite along with this application.	concer	ns, do	cumen	ntation rel	lating to the concern mus
Professional Diagnosis (speech therapy, occupational, etc.): *Please note: If child receives treatment for any medical oprovided along with this application. Health Services: My child receives medical treatment for:					
Professional Diagnosis (speech therapy, occupational, etc.): *Please note: If child receives treatment for any medical oprovided along with this application. Health Services: My child receives medical treatment for: List all known allergies, dietary needs or other medical/dental	concei	rns: 🗆 A	Anemia	a □Asthm:	
Professional Diagnosis (speech therapy, occupational, etc.): *Please note: If child receives treatment for any medical oprovided along with this application. Health Services: My child receives medical treatment for: List all known allergies, dietary needs or other medical/dental High Lead Level Other, specify	concei	rns: 🗆 A	Anemia	a □Asthm:	
Professional Diagnosis (speech therapy, occupational, etc.): *Please note: If child receives treatment for any medical oprovided along with this application. Health Services: My child receives medical treatment for: List all known allergies, dietary needs or other medical/dental	concei	rns: 🗆 A	Anemia	a □Asthm:	
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*Please note: If child receives treatment for any medical obrovided along with this application. Health Services: My child receives medical treatment for: List all known allergies, dietary needs or other medical/dental High Lead Level Other, specify Describe: Services If offered and your location preference is unavailable would	concer	rns: 🗆 A	Anemia	a □Asthm: nown	

Monroe County Public School Head Start Program Homeless Verification

Child's Name:	_							
Denot / Conding Disease healt all that and a								
Parent / Guardian: Please check all that apply: Housing	Yes	Is any member of your household? If so please						
Home that I rent, own or share by choice	103		r yes	ioer of your	nousenous. If so pieuse			
Temporarily living with a family member or friend	Co. Dick William Co.	Member of U.S Military						
loss of housing, economic hardship or similar reas	on			ary ary Veteran				
Subsidized (Section 8, HUD, Rent Assistance)								
At Risk of Homeless			-		tion provided in this			
Homeless		prov	rided fo	r enrollment	I proof of age income eligibility, is accurate and			
Staying in emergency or transitional shelter/housing	ng				knowledge. I am aware that			
Living in a motel /campground vehicle because I cafford or find affordable housing	cannot			om the progr	nformation could result in ram.			
Moved more than 3 times in 12 months		Parent/Guardian Print Name:						
					Date:			
Parent/Guardian Signature:	Date:							
*Under McKinney-Vento, determinations of eligibility if assistance is needed.					ify the Homeless Liaison to			
Status		No	Yes					
Family be hom	is determined to neless							
By signing this document I declare that I have revi am aware that if I intentionally violate federal, pro that it will result in some form of disciplinary action	gram eligibility dete							
Staff Print Name:	Date:							
Staff Signature:								