ELIGIBILITY PRIORITY CRITERIA
For Agency Use Only

Child's Name ____ Birthday ____/____/____

Instructions: Check one box in each area based on information from the enrollment application, CCFP application, and/or other sources. When appropriate, write in comments to document reason for selection. Sign form below and attach to application. The "DESCR" and "PTS" for each item checked should be copied on to the application, lines A13-A15. If no points given for item checked, leave those items blank when copying on to application.

AREA	DESCR	PTS	SELECT
PARENTAL STATUS (see Application, Page 1, Line 8)			
O – One Parent	ONE	30	( )
T – Two Parent	TWO	10	( )
F – Foster Parent	FOSTR	20	( )
N – Not the child's Parent	OTHER	20	( )

Comments:

AREA	DESCR	PTS	SELECT
HANDICAP (see Application, Page 1, Line 10 & A10 "Hdcp")			
Z – Zero Handicap		00	( )
X – Potential or Suspected	SUSP	20	( )
B to W (Diagnosed Condition – abbreviate type)	_____	40	( )

Comments:

AREA	DESCR	PTS	SELECT
INCOME (see Application, Page 1, Line A9 – "Inc Status" & "Amount")			
Low Income/75% Below Poverty Guidelines*	L75%	90	( )
Low Income/50% Below Poverty Guidelines*	L50%	80	( )
Low Income/25% Below Poverty Guidelines*	L25%	70	( )
Eligible/0-24% Below Poverty Guidelines*	ELIG	60	( )
Over-Income/1% to 30% Above Poverty*	OV30%	40	( )
Over-Income/31% to 85% Above Poverty**	OV85%	30	( )
Over-Income/Over 85% Above Poverty)	OVER	00	( )

*Free Lunch Eligible **Reduced Lunch Eligible

Comments:

AREA	DESCR	PTS	SELECT
OTHER (see Application, Page 1, Line 10 & 13; Page 1, "Comments")			
No Apparent Social Service or Special Need		00	( )
Single Social Service or Special Need	SINGL	30	( )
Multiple Social Service or Special Needs	MULTP	60	( )

Check Need(s) and describe In Comments below:

- __Abuse/Neglect
- __Serious Child Health Problem
- __Other ____________________
- __Referral from other Agency/Professional
- __High Risk (Mental Illness/Disabled Adult)
- __Family Crisis (Terminal Illness, Death)

Comments:

AREA	DESCR	PTS	SELECT
AGE BY OCTOBER 1 (see Application, Page 1, Line 1 & A10 "Age")			
Returnee – 4 years or older	RET	90	( )
4 years 6 months and old	4-__	70	( )
4 years 0 months to 4 years 5 months	4-__	60	( )
3 years 6 months to 3 years 11 months	3-__	30	( )
3 years 6 months to 3 years 5 months	3-__	20	( )

Comments:

Signature of Staff Completing Form ______________________________ Date ____________

Head Start Eligibility Verification

1. Child's name: ______________________

2. Child's date of birth: ______________________

3. Check the applicable category of eligibility for this child:

- ☐ Income *(check box that applies):*
  - ☐ *Below federal poverty guidelines*
  - ☐ *Between 100-130% of federal poverty guidelines (no more than 35% of enrolled children may fall into this category)*
- ☐ Over- Income
  - ☐ *Counted as part of 10% maximum for non-AI/AN programs)*
  - ☐ *Counted as part of the 49% maximum for AI/AN programs)*
- ☐ Public assistance
- ☐ SSI
- ☐ Homeless
- ☐ Foster Care

4. What documentation was used to determine eligibility?

- ☐ Income Tax Form 1040
- ☐ W-2
- ☐ TANF documentation
- ☐ Pay stub or pay envelopes
- ☐ Unemployment
- ☐ Written statements from employers
- ☐ Foster care reimbursement
- ☐ SSI documentation
- ☐ Other

If Other, please explain: ____________

Documentation of no income: ______________________

5. Staff signature: ______________________ Date of eligibility verification: ______________________

6. Staff name: ______________________ Title: ______________________