Lower Elwha Klallam Tribe

Head Start/Early Head Start
463 Stratton Rd, Port Angeles, WA, 98363
360-452-8471 ext 158 or 360-452-2587
Fax 360-452-5105

Thank you for your interest in the Lower Elwha Klallam Tribes Early Childhood Programs. Classes are Tuesday-Friday for both Head Start and Early Head Start with Head Start classes from 9:30am-1pm and Early Head Start classes from 9am-3pm. In addition Early Head Start provides services to pregnant women and is a full year program.

ELIGIBILITY REQUIREMENTS

Age Eligibility: For Head Start - Your child must turn 3 yrs old AND must not turn 5 yrs old by August 31st
For Early Head Start – Your child must be at least 1 month and not yet 3 yrs. old

Categorically Eligible: Your family has increased eligibility if you are in any of the following categories

- The child to be enrolled is in foster care
- The family is receiving benefits from TANF or GA
- A family member living with and supported by you is receiving Supplemental Security Income benefits (SSI)
- The family is homeless

Children with disabilities: Children with disabilities have increased eligibility for Head Start/Early Head Start. If the child has a current Individualized Education Plan (IEP) or for Early Head Start the child has a current Individual Family Service Plan (IFSP) you may not need to be income eligible.

REQUIRED DOCUMENTS

To be considered for enrollment your application must be complete and include copies of the following documents (***documents will not be returned***):

- ***Birth Certificate***
- ***Immunization Records***
- ***Income Verification –*** Documentation that reflects current household income from *all* sources:
  - ✓ Current pay stubs showing one month of income
  - ✓ Letter from employer stating hours worked per week and pay rate
  - ✓ Social Security Income (SSI)
  - ✓ Latest Income Tax Return
  - ✓ Unemployment Income
  - ✓ Child Support
  - ✓ Disability Income
- ***Proof of Legal Custody*** (if child is in foster care)
- ***Notice of Action*** (if receiving TANF/GA)
- ***Current IEP*** (Head Start) **or** ***IFSP*** *(*Early Head Start) (if applicable)
- ***Tribal Enrollment (CIB) or Descendancy Verification***
- ***Copy of Child's Insurance Card***
- ***Childs most recent Physical/Well child exam***

SUBMITTING YOUR APPLICATION

Once you have completed the application, you may submit by mail or hand delivery to: 463 Stratton Rd, Port Angeles, WA, 98363

You will be contacted by phone or mail once your application has been processed.

A completed application is *not* a guarantee of enrollment. Enrollment is based on child and family dynamics.

If you have any questions please call Jessica at (360) 452-2587, Monday through Friday, 8:30 a.m. to 4:00 p.m.

Tonya Ritchie, Director 452-8471 x 157
Rosemary Newday, Education/Disability Manager
Deanna Picard, Health Manager 452-2587
Denise Huff, Prenatal Educator
Resource Manager 452-2587

Jessica Wright, Family Community
Partnership Manager/Enrollment 452-2587
Teaching Staff 452-8471 x160

Lower Elwha Head Start/Early Head Start

Please print all information and fill in the form completely and accurately

☐ Early Head Start (1 month—3 yrs) ☐ Head Start (3—5 yrs)

Child (Applicant)

First Name	Last Name	Middle	Gender	Date of Birth	Social Security Number
			[ ]Male [ ]Female	/ /	- -

Race	Ethnicity
[ ] American/Alaskan Indian [ ] Black/African American [ ] White [ ]Asian [ ]Biracial/ Multi-Racial [ ]Native Pacific Islander/Hawaiian [ ]Other:_____	[ ]Hispanic [ ] Non-Hispanic

Primary Language _____ How well does he/she speak [ ] None [ ] Poor [ ] Moderate [ ] Well

Primary Language Spoken at Home [ ] English [ ] Spanish [ ] Other_____

Household Information

Head of Household's Name	Relationship to Child

List all family members living in the household:

First Name	Last Name	Date of Birth	Relationship to child	Is this person supported by the parent'(s) income?
		/ /		[ ] Yes [ ] No
		/ /		[ ] Yes [ ] No
		/ /		[ ] Yes [ ] No
		/ /		[ ] Yes [ ] No
		/ /		[ ] Yes [ ] No
		/ /		[ ] Yes [ ] No

Total Number of people living in the household (including you) for <u>whom you provide</u> financial support ☐

Childs Physical Address	City/Zip	[ ] Is Family currently homeless
Mailing Address (if different)	City/Zip	

Home phone [ ] Primary Phone	Cell Phone [ ] Primary Phone	Work Phone [ ] Primary Phone

Parent/Guardians in the Home	Name of Childs Legal Custodian	Is the child in foster care?
[ ] One Parent [ ] Two Parents		[ ] Yes [ ] No

Is the child living with a relative or friend due to incarceration or abandonment? (excluding foster children) [ ] Yes [ ] No

Do you or a family member living with and supported by you receive Supplemental Security Income (SSI)? [ ] Yes [ ] No

Other Family members or friends we can contact in case we are unable to reach you

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Lower Elwha Head Start/Early Head Start

Child's Name_____ Birth Date _____

Mother/Guardian			**Father/Guardian**		
First Name	Last Name		First Name	Last Name	
Lives with Child Y N	Legal Custody Y N	Date of Birth / /	Lives with Child Y N	Legal Custody Y N	Date of Birth / /
Social Security Number _____-_____-_____			Social Security Number _____-_____-_____		
Marital Status [ ]Married [ ]Single [ ]Separated [ ]Divorced [ ]Widowed			Marital Status [ ]Married [ ]Single [ ]Separated [ ]Divorced [ ]Widowed		
Do you receive Child Support? [ ] Yes [ ] No If yes, amount per month $			Do you receive Child Support? [ ] Yes [ ] No If yes, amount per month $		
Highest Grade Completed:			Highest Grade Completed:		
Race/Ethnicity: [ ] American/Alaskan Indian [ ]Asian [ ] Black/African American [ ] White [ ]Biracial/ Multi-Racial [ ]Native Pacific Islander/Hawaiian [ ]Other:_____			Race/Ethnicity: [ ] American/Alaskan Indian [ ]Asian [ ] Black/African American [ ] White [ ]Biracial/ Multi-Racial [ ]Native Pacific Islander/Hawaiian [ ]Other:_____		
Employment Status: [ ] Employed [ ] Seasonally Employed [ ] Unemployed [ ] Retired [ ] Seeking Employment [ ] Disabled [ ] Incapacitated [ ] Other_____ Dates of incapacitated From_____ To_____			Employment Status: [ ] Employed [ ] Seasonally Employed [ ] Unemployed [ ] Retired [ ] Seeking Employment [ ] Disabled [ ] Incapacitated [ ] Other_____ Dates of incapacitated From_____ To_____		
Employer Name	Employer Phone		Employer Name	Employer Phone	
Employer Name	Employer Phone		Employer Name	Employer Phone	
Work Schedule (include all jobs) Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____			Work Schedule (include all jobs) Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____		
Pay Days are [ ] Weekly [ ] Every 2 Weeks [ ] Twice per Month [ ] Monthly Gross Income $_____ Per _____			Pay Days are [ ] Weekly [ ] Every 2 Weeks [ ] Twice per Month [ ] Monthly Gross Income $_____ Per _____		
Do you receive TANF or GA [ ] Yes [ ] No If yes, amount per month $_____			Do you receive TANF or GA [ ] Yes [ ] No If yes, amount per month $_____		
Do you have any additional sources of income? [ ] Yes [ ] No If yes, amount per month $_____ Description:_____			Do you have any additional sources of income? [ ] Yes [ ] No If yes, amount per month $_____ Description:_____		
Are you in School or Training? [ ] Yes [ ] No			Are you in School or Training? [ ] Yes [ ] No		
School Name	School Phone		School Name	School Phone	
School or Training Schedule Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____			School or Training Schedule Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____		

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services. I will notify the agency immediately if there is any change in my income, family size, residence, employment or reason for needed child care services.

Parent/Guardians Signature _____ Date _____

Lower Elwha Head Start/Early Head Start

Child's Name_____ Birth Date _____

Health Information and History				
Medical Provider	Phone ( ) -	Address	City	Zip
Dental Provider	Phone ( ) -	Address	City	Zip

Health Coverage: [ ] No insurance [ ] State Medical Coupons [ ] Private Insurance [ ] Indian Health Services

Insurance Company _____Policy # _____ Group #_____
Address_____

Other Health Coverage

Immunizations

Before your child is placed on a class list, a copy of your child's current immunization records must be received by the program according to the State of Washington Immunization requirements. All immunizations must be recorded by showing a date given and signature or stamp verification by health care provider. If your child is missing an immunization or has not received all required immunizations; call your local health care provider as soon as possible to make an appointment.

Child's Medical History

Date of child's last Well Child Exam _____

Date of child's last Dental Exam _____

Is your child receiving WIC services? _____ WIC ID Number_____ Which Clinic? _____

Medications [ ] Yes [ ] No

List all medications; prescriptive and non-prescriptive, that your child takes regularly

Your child will not be given medication at school without a Physician's note and Classroom Health Plan

Allergies [ ] Yes [ ] No

List all allergies; food, medication, environmental or other

Special Diet [ ] Yes [ ] No

List special dietary needs

If a special diet is required, physician documentation will be needed

Nutrition Information

Does your child experience any of the following symptoms after eating?

[ ] Diarrhea [ ] Itching [ ] Vomiting [ ] Difficulty Swallowing [ ] Other _____

Early Head Start	
Is your child Breastfed? _____ Will you provide Breast milk? _____	If your child uses formula, what Brand/Type? _____
What type of Diapers does your child wear? _____ What size? _____	What type of wipes do you use?

Maternal and Pregnancy Health History			
Did you receive regular prenatal care? [ ] Yes [ ] No		Number of weeks pregnant at Birth? _____	
Name of Doctor/Midwife	Address		Phone ( ) -
Were there or are there any medical concerns for your pregnancy? [ ] None [ ] Preterm labor [ ] Bed rest [ ] Abnormal tests [ ] Other:_____ [ ] Medications: _____			
Did you or do you have any of the following concerns with your pregnancy: [ ] None [ ] Underweight [ ] Overweight [ ] Violent Household [ ] Other			
While pregnant did the mother drink alcoholic beverages that could have affected the development of the child?	[ ] Yes [ ] No	While pregnant did the mother take any drugs that could have affected the development of the child?	[ ] Yes [ ] No
If yes, to any of the above, please explain:			

Birth History			
Was your child premature?	[ ] Yes [ ] No	Did your child have jaundice?	[ ] Yes [ ] No
Was your child exposed the cigarette smoke?	[ ] Yes [ ] No		

Special Health Needs/ Chronic Illness	**Check a box**
Asthma	[ ] Yes [ ] No
Anemia	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No
Pediatric First Aid Needs	[ ] Yes [ ] No
Other Special Health Needs, Please explain:	[ ] Yes [ ] No

Ears and Eyes			
Any trouble hearing?	[ ] Yes [ ] No	Any trouble with his/her eyes?	[ ] Yes [ ] No
Uses a hearing device?	[ ] Yes [ ] No	Has your child ever worn glasses?	[ ] Yes [ ] No
If yes, to any of the above, please explain:			

Family History			
Mother's Health Status	[ ] Good [ ] Fair [ ] Poor	Father's Health Status	[ ] Good [ ] Fair [ ] Poor

SOCIAL-EMOTIONAL DEVELOPMENT			
Does your child have:			
Severe fears?	[ ] Yes [ ] No	Aggressive behaviors?	[ ] Yes [ ] No
Problems getting along with other family members?	[ ] Yes [ ] No	Problems separating from parent/guardian	[ ] Yes [ ] No
Problems sleeping?	[ ] Yes [ ] No	Extreme shyness?	[ ] Yes [ ] No
Temper tantrums?	[ ] Yes [ ] No	Other concerns you may have about your child's behavior	
Problems getting along with other children the same age?	[ ] Yes [ ] No		
Currently receiving mental health services? [ ] Yes [ ] No		**If yes,** agency name	

Disabilities:	
Does your child have an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP)? **If yes,** please attach copy of the most recent IEP or IFSP.	[ ] Yes [ ] No IEP or IFSP
Do you have any Disability or Developmental concerns about your child? Please explain	[ ] Yes [ ] No

Lower Elwha Head Start/Early Head Start

Child's Name_____ Birth Date _____

Child Care Subsidy and Extended Day Care	
Do you receive child care subsidy? [ ] Yes [ ] No [ ] Working Connections [ ] CCDF [ ] DSHS [ ] CPS [ ] TANF [ ] Other_____	
What type of child care does your child attend? [ ] Family child care home [ ] Child care center [ ] A relative at child's home/ or relative home [ ] Public school pre-Kindergarten program [ ] Other child care arrangements [ ] Does not attend	Do you receive full day/full year care for your child? [ ] Yes [ ] No Do you receive Part Time or Drop-in care for your child? [ ] Yes [ ] No Does your household have a need for child care services? [ ] Yes [ ] No

Lower Elwha Head Start/Early Head Start Permission Form (Please Initial each box)	
	I give permission for my child to take part in planned and spontaneous field trips away from the center.
	I give permission to the center for my child to participate in activities including holiday festivals. Holiday activities will not be planned that will exclude any child from participating.
	I give permission for my child to be transported by Head Start buses, automobile or public transportation.
	I give permission for my child to have routine health screenings; speech and language, hearing, vision, dental and general physical health.
	I give permission for my child to have their picture taken individually or in a group setting, for record keeping, display in the classroom or center and for advertisement or marketing purposes.
	I authorize the Lower Elwha Staff to administer first aide; take my child to the nearest emergency center; or summon an ambulance for emergency medical care when necessary. If an emergency arises, I understand I will be notified as soon as possible. I will be financially responsible for all cost incurred for each service.
	I do herby waive, absolve, release, indemnify and hold harmless the staff or any person aiding the staff, for any accident or injury sustained by my child while enrolled at the center or while be transported to or from the center, except to the extent covered by liability insurance carried by the tribe for the center.
	I wish to decline the blood test for lead screening of my child. I understand that Washington State requires physicians to assess the risk of lead exposure. If my child's doctor recommends this blood test, I will notify Head Start of the results.

Did you remember the following?

[ ] Complete application (all questions answered)
[ ] Tribal enrollment documentation/CIB
[ ] Birth certificate
[ ] Food Program
[ ] Income verification
[ ] Medication/Allergies/Food Substitution
[ ] Immunization records
[ ] Copy of most recent physical exam
[ ] Special diet physician request
[ ] Child release form
[ ] Insurance Card

_____ _____
Parents Signature Date

_____ _____
Staff Signature and Position Date

Child Release Form
Lower Elwha Klallam Tribe Head Start & Early Head Start
452-2587 or fax 452-5105

Child's Full Name _____ DOB _____

_____ _____
Mother/Guardian Father/Guardian

_____
Home Address (Street) City State Zip

_____ _____ _____
Home Phone Cell Phone Message Phone

_____ _____
Mother Work Phone Fathers Work Phone

****NO CHANGES WILL BE MADE DAILY FOR PICK-UP OR DROP-OFF****

We need the address and phone number of where the child will be picked-up and dropped off on a daily basis. We cannot make changes to the bus routes; it makes for a long and stressful bus ride for the children. Children feel safer when there is consistency and continuity in their lives. If for some reason your child does not need transportation call 452-8471 Ext. 158 ***(only for Head Start)***

_____ _____ _____
Morning Pick-up Address Person putting child on bus Phone #

_____ _____ _____
Afternoon Pick-up Address Person putting child on bus Phone #

Do not release my child to (Please provide court documentation):

WE ALSO ***REQUIRE*** THE NAMES AND PHONE NUMBERS OF ***THREE PEOPLE*** TO WHOM WE CAN RELEASE YOUR CHILD TO. KEEP IN MIND THAT THESE PEOPLE NEED TO BE OVER 12 YEARS OF AGE (HEAD START) AND 18 YEARS OF AGE (EARLY HEAD START & CHILD CARE) AND BE ABLE TO SHOW PICTURE ID. SO NOT INCLUDE YOURSELF AS AN EMERGENCY CONTACT; THESE THREE PEOPLE MUST HAVE A ***CURRENT WORKNG PHONE NUNBER AND ADDRESS***. PLEASE INFORM THESE THREE PEOPLE THAT THEY ARE THE EMERGENCY CONTACT.

1. _____ _____
Name Relationship to child
_____ _____
Address Home & Cell #
2. _____ _____
Name Relationship to child
_____ _____
Address Home & Cell #
3. _____ _____
Name Relationship to child
_____ _____
Address Home & Cell #

Medical Provider	Phone ( ) -	Address	City	Zip
Dental Provider	Phone ( ) -	Address	City	Zip

Health Coverage: [ ] No insurance [ ] State Medical Coupons [ ] Private Insurance [ ] Indian Health Services

Insurance Company _____Policy # _____ Group #_____
Address_____

In signing, I acknowledge agreement to the statement above.

_____ _____ _____
Parent/Guardian Signature Email Address Date

Permission to Exchange Confidential Information
Lower Elwha Klallam Tribe
Head Start /Early Head Start

I give my permission for the Lower Elwha Head Start and Early Head Start to mutually exchange information concerning my child

Name: _____ Date of Birth: _____ Today's Date: _____,
with the following agencies.

Agency or Individual (Example: WIC, Doctor, School District, etc.)	Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please initial those for which permission is given:

_____ Medical/Dental Records/Notes
_____ Family Service Records
_____ Educational Records/Reports/Observations
_____ Special Education Records/Reports/Evaluation
_____ Behavioral Observations
_____ Childcare Assistance/Family Goals
_____ Social Services
_____ Other_____
_____ **All of the above**

I understand that this information will not be shared with any other agencies or individuals without my written permission. My consent is voluntary, and unless revoked, shall stand as valid for 12 months from the date of my signature.

_____	_____	_____
Parent/Guardian Signature	Phone #	Date

_____
Relationship to Enrolled Child

_____	_____	_____
Staff Signature	Position	Date

Please keep a copy for your records
Copy in Education file
Copy in Family File
Copy in Health File

Child and Adult Care Food Program
ENROLLMENT FORM

PART 1 – CHILDREN'S INFORMATION

Child's Name	Birthdate	Circle Normal Days/ Print Normal Hours of Care	Circle Meals Normally Received
		Sun Mon Tu Wed Th Fri Sat Normal Hours 9am to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

PART 2 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You Are Not Required to Answer This Part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

If you feel you have been discriminated against, you should write the Secretary of Agriculture, Washington, DC 20250.

PART 3 – SIGNATURE

Signature of Adult	Date	Print Name of Adult Signing

Mailing Address	City/State/Zip Code	Daytime Phone

Year 2

Signature of Adult	Updated	Print Name of Adult Signing

Year 3

Signature of Adult	Updated	Print Name of Adult Signing

Reviewed by: Staff Signature	Date:	Is there an accompanying signed Certificate of Exemption on file? ☐ Yes ☐ No

Washington State Department of Health

DOH 348-013
Rev: 10/15/08

Certificate of Immunization Status (CIS)

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:		Child's Sex:	
Parent/Guardian Name:			Parent/Guardian Day Phone:

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age
◆ **Hepatitis B (Hep B)**			
	1		
	2		
	3		
Hepatitis B (Hep B) Alternate schedule for teens			
	1		
	2		
Rotavirus			
	1		
	2		
	3		
◆ **Diphtheria, Tetanus, Pertussis** (DTaP, DTP, DT)			
	1		
	2		
	3		
	4		
	5		
◆ **Diphtheria, Tetanus, Pertussis** (Tdap, Td)			
	1		
	2		
● ***Haemophilus influenzae* type b (Hib)**			
	1		
	2		
	3		
	4		

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

Vaccine	Dose	Date	Age
● **Pneumococcal (PCV, PPV)**			
	1		
	2		
	3		
	4		
◆ **Polio (IPV, OPV)**			
	1		
	2		
	3		
	4		
Influenza (most recent)			
◆ **Measles, Mumps, Rubella (MMR)**			
	1		
	2		
◆ **Varicella (chickenpox)**			
	1		
	2		

Vaccine	Dose	Date	Age
Hepatitis A (Hep A)			
	1		
	2		
Meningococcal (MCV4, MPSV4)			
	1		
Human Papillomavirus (HPV)			
	1		
	2		
	3		
Other			

I certify that the information provided here is correct and verifiable.

Signature of Parent or Guardian Date

▼ **Verification of varicella disease history** ▼

☐ Health Care Provider (HCP) Verified ▶	☐ Signed note from HCP attached or ☐ HCP provider signature here: ▶	
☐ HCP Verified by Registry ▶	No HCP Sig required if box at left checked.	**If school staff find verification in the Registry, then school staff must:** ▶
☐ Parental Report ▶	**ONLY** acceptable for some grades. Write date or age child had disease:	

Licensed HCP Signature (MD, DO, ND, PA, ARNP) Date

Either initial with parent approval or get parent signature below:

Staff initials indicating parent approval: _____

Parent Signature indicating approval: _____

FOR OFFICE USE ONLY

I certify that I have examined the following income documentation:

[ ] Tax Form	[ ] W-2 Form	[ ] Verified by Employer	Gross Annual Income
[ ] Pay stubs	[ ] Public Assistance	[ ] Child Support	
[ ] Foster Child Doc.	[ ] SSI	[ ] Unemployment	$

Family is: [ ] Income Eligible [ ] Over Income

Verifying staff signature: Position: Date

I have copied the following:	Enrollment Date:	Date on Waiting List:
[ ] Birth Cert [ ] Tribal CID/CIB [ ] Immunization		

Completed Application Checklist

Do you have the following with the application?

[ ] Complete application (all questions answered)
[ ] Tribal enrollment documentation/CIB
[ ] Birth certificate
[ ] Child release form
[ ] Letter from Doctor for medication/allergies/food substitution
[ ] Food Program
[ ] Income verification
[ ] Immunization records
[ ] Copy of most recent physical exam
[ ] Copy of Insurance Card

Notes: DSHS Caseworker/ICW, Restraining Order, Court Order's, Other….

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: _____