

## SPCAA Early Head Start 2010 Selection Criteria

Note: The following selection form is adapted from SPCAA Head Start, Rev. 9-2-10.

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Instructions:** Check one criterion in each area based on information from the application and/or other sources. When appropriate, write in comments in each area to support points awarded. Write in selected points for each area in space provided. Add up points by area and write in total and sign. **(\*) Documentation must be attached.**

AREAS	DESCR.	PTS	SELECT	PTS
				AREA
<b>FAMILY STATUS</b> (select one)				
*F - Foster Child (Authorized Care)	FOST	72	( )	
G- Guardian/Caretaker	G	50	( )	
SWP - Single Working Parent or Student	SWP	60	( )	
SP – Single Parent, Not working or Student	SP	30	( )	
TWP - Two Parents, Both Working or Students	TWP	40	( )	
TPOW – Two Parents, One Working or Student	TPOW	20	( )	
TP - Two Parents, Neither Working or Student	TP	10	( )	
MV – McKinney Vento Act	MV	70	( )	

Comments: \_\_\_\_\_

<b>SPECIAL NEED</b> (select one)				
<i>(MUST be approved by Mental Health/Disability manager if points given, Documentation must be attached )</i>				
No Suspected Special Need/Disability	Z	0	( )	
X - Potential or Suspected Special Need/Disability	SUSP (X)	40	( )	
*A To Y - (Diagnosed Condition – Abbreviated Type)	_____	70	( )	

Comments: \_\_\_\_\_

<b>INCOME</b> (select one)				
Eligible Due To Public Assistance	EPA	70	( )	
Income Eligible at or Below Poverty Level	ELIG	70	( )	
Low Income 25% Below Poverty Level	L25%	80	( )	
Low Income 50% Below Poverty Level	L50%	90	( )	
Low Income 75% Below Poverty Level	L75%	100	( )	

Comments: \_\_\_\_\_

<b>AGE OF CHILD at Recruitment</b> (select one)				
6 weeks - 6 months	_____	20	( )	
7 months – 12 months	_____	30	( )	
13 months – 18 months	_____	40	( )	
19 months – 23 months	_____	20	( )	
24 months – 30 months	_____	30	( )	
31 months – 35 months	_____	40	( )	

Comments: \_\_\_\_\_

<b>OTHER</b> (select all that apply)				
Referral from other Agency/Professional	REF	40	( )	
Family Health Problems/Disability	FHP/D	30	( )	
Family In Transition	FT	30	( )	
No Referral	NR	0	( )	
*Eligible due to McKinney-Vento	EMV	101	( )	

Comments : \_\_\_\_\_

<b>PREGNANT MOTHER</b> (*Attach proof of pregnancy from medical provider) (select one)				
Pregnant 1 (13 – 16yr)	P1	40	( )	
Pregnant 2 (17 – 21 yr)	P2	30	( )	
Pregnant 3 (22 – 34 yr)	P3	20	( )	

