INCOME POVERTY GUIDELINES

February 1, 2023

GROSS INCOME

FAMILY SIZE	ANNUALLY	SEMI-ANNUALLY	QUARTERLY	MONTHLY	WEEKLY
			100% Head Start / Early Head Start		
1	14,580.00	7,290.00	3,645.00	1,215.00	280.38
2	19,720.00	9,860.00	4,930.00	1,643.33	379.23
3	24,860.00	12,430.00	6,215.00	2,071.67	478.08
4	30,000.00	15,000.00	7,500.00	2,500.00	576.92
5	35,140.00	17,570.00	8,785.00	2,928.33	675.77
6	40,280.00	20,140.00	10,070.00	3,356.67	774.62
7	45,420.00	22,710.00	11,355.00	3,785.00	873.46
8	50,560.00	25,280.00	12,640.00	4,213.33	972.31
			130% SVG Limit		
1	18,954.00	9,477.00	4,738.50	1,579.50	364.50
2	25,636.00	12,818.00	6,409.00	2,136.33	493.00
3	32,318.00	16,159.00	8,079.50	2,693.17	621.50
4	39,000.00	19,500.00	9,750.00	3,250.00	750.00
5	45,682.00	22,841.00	11,420.50	3,806.83	878.50
6	52,364.00	26,182.00	13,091.00	4,363.67	1,007.00
7	59,046.00	29,523.00	14,761.50	4,920.50	1,135.50
8	65,728.00	32,864.00	16,432.00	5,477.33	1,264.00
133% Title XIX (mothers & children, ages 1-18)			145% CCBG Limit		
1	21,141.00	10,570.50	5,285.25	1,761.75	406.56
2	28,594.00	14,297.00	7,148.50	2,382.83	549.88
3	36,047.00	18,023.50	9,011.75	3,003.92	693.21
4	43,500.00	21,750.00	10,875.00	3,625.00	836.54
5	50,953.00	25,476.50	12,738.25	4,246.08	979.87
6	58,406.00	29,203.00	14,601.50	4,867.17	1,123.19
7	65,859.00	32,929.50	16,464.75	5,488.25	1,266.52
8	73,312.00	36,656.00	18,328.00	6,109.33	1,409.85
			150% LiHeap		
1	21,870.00	10,935.00	5,467.50	1,822.50	420.58
2	29,580.00	14,790.00	7,395.00	2,465.00	568.85
3	37,290.00	18,645.00	9,322.50	3,107.50	717.12
4	45,000.00	22,500.00	11,250.00	3,750.00	865.38
5	52,710.00	26,355.00	13,177.50	4,392.50	1,013.65
6	60,420.00	30,210.00	15,105.00	5,035.00	1,161.92
7	68,130.00	34,065.00	17,032.50	5,677.50	1,310.19
8	75,840.00	37,920.00	18,960.00	6,320.00	1,458.46
185% WIC CCBG limit Children w/IEP or IFSP only			200% *hawk-I,*	Title XIX (mothers & infants, to age	
1	29,160.00	14,580.00	7,290.00	2,430.00	560.77
2	39,440.00	19,720.00	9,860.00	3,286.67	758.46
3	49,720.00	24,860.00	12,430.00	4,143.33	956.15
4	60,000.00	30,000.00	15,000.00	5,000.00	1,153.85
5	70,280.00	35,140.00	17,570.00	5,856.67	1,351.54
6	80,560.00	40,280.00	20,140.00	6,713.33	1,549.23
7	90,840.00	45,420.00	22,710.00	7,570.00	1,746.92
8	101,120.00	50,560.00	25,280.00	8,426.67	1,944.62

FOR FAMILY UNITS WITH MORE THAN 8 MEMBERS ADD $5140 FOR EACH ADDITIONAL MEMBER. MULTIPLY THE RESULTING FIGURE BY .75 TO CALCULATE 75% FIGURE, 1.25% TO CALCULATE 125% FIGURE, 1.5 TO CALCULATE 150% FIGURE, AND 1.75 TO CALCULATE THE 175%FIGURE.

HEAD START APPLICATIONS:

Please complete both forms attached (if not filled out completely the application will not be processed) and bring the following:

Head Start is a free preschool experience for income eligible families. In order for a Head Start application to be complete and processed and the child put on a waiting list, income verification is needed showing 12 months of income for parents listed in household. Below are different ways that income may be verified:

- Federal tax return forms for 2022 1040 form
- Pay stubs for the last 12 months
- Printout from your employer on company letterhead
- SSI benefits – award letter, copy of monthly check, or bank statement if direct deposited
- Child Support/Alimony – printout
- Iowa Workforce – printout for the past 5 quarters
- FIP – printout showing any benefits for the previous 12 months including the signature date on the Head Start application.
- SNAP benefits – Notice of Decision letter or Copy of SNAP card, showing parents name.
- College Students – scholarships or grants
- Copy of VISA if unable to work.

Please note that whatever you mark for income on the application, you will need to provide documentation for.

Applications may be dropped off at any of our Head Start Locations, scanned and emailed to Hacap.org, or mailed to this location:

HACAP
1515 Hawkeye Drive
Hiawatha Iowa 52233
Att. Stacy King

Application Check Sheet

Child's Name: _____ Date: _____

A staff member completed the intake with the parent: _____

No in-person intake was completed with parent because:

No staff available: _____ Application was mailed: _____ Another agency worked w/parent: _____

Online app:_____ Other: _____

A phone interview was completed by: _____ Date:_____

First Attempt: _____ Second Attempt: _____

Application data entered/updated in ChildPlus: _____

Application has both parent and staff signature and date: _____

Application has been pointed, signature, and date: _____

Application is complete and has income: _____

Staff Signature: _____ Date: _____

Notes: _____

_____

_____

_____

_____

_____

_____

Performance Standard 1302.12 (K)

Revised Jan 23

APPLICATION COVER SHEET

(Must be complete and attached to <u>all</u> applications/files sent to Corporate for enrollment)

● **CHILD NAME:** _____ ● **CHILD DATE OF BIRTH:** _____

● **HACAP HOUSING:** Yes No ● **POINTS:** _____ ● **PROGRAM:** _____

● **APPLICATION COMPLETED AT:** _____ ● **DATE:** _____
(location)

● **SITE REQUESTED (1ST Choice)** _____ **(2nd Choice)** _____

● **CURRENT SCHOOL DISTRICT** _____

FAMILY NEED HS Full Day (10 hr.)_____ HS School Day (8 hr.)_____ HS Part Day (4 hr) Mon-Fri____
EHS Center Based (10 hr.)____ EHS Home Based_____

FAMILY INFO (Misc.)

1. What is the best way to contact you? Email___ Email Address:_____
   Phone____ Phone No._____ Text_____ Letter ____
   _____*Initial here to authorize this method of communication*
2. Health Insurance through_____ Policy Number: _____
3. Health Insurance through Indian Health Center/Service _____yes _____no
4. DHS Child Care Assistance (DHS CCA): Applied_____ Receiving_____
5. How did you hear about Head Start? _____

ABBREVIATED NUTRITION ASSESSMENT – <u>Must be completed at time of application</u>

1. **Parent concerns about child eating in the Head Start classroom?** **Yes** **No**
2. **Any special diet modifications child must follow?** **Yes** **No**
   (i.e. medical diet, food allergies)
   If yes, a Food Allergy/Special Medical Diet Form must be completed and sent to the CACFP Manager.
   Please complete and attach.
3. **Any religious dietary restrictions we should know about?** **Yes** **No**
   If yes, explain _____
4. **Are you participating in WIC?** **Yes** **No**
   If yes, when was the child's last certification? _____
5. **Are you receiving food stamps/SNAP?** **Yes** **No**
6. **Are you able to provide adequate meals for your family?** **Yes** **No**
   (i.e. do you run out of food*, does your refrigerator/stove work?) *Encourage community resources as needed

NEEDS – <u>Must be completed at time of application</u>

1. **Suspected Disability** **Yes** **No**
   If yes, suspected disability reported by: _____
2. **Professionally Diagnosed Disability** **Yes** **No**
   If yes, describe: _____
   Disability professionally diagnosed by: _____

   Documented diagnosis/verification included with application **Yes** **No**
   included with application?
3. **Special Health Concerns** **Yes** **No**
   If yes, describe: _____

Hawkeye Area Community Action Program, Inc.
1515 Hawkeye Drive, PO Box 490, Hiawatha, IA 52233

Basic Intake Form – HS/EHS

Flag for Review
Red – Health
Blue – Disability
Yellow – Nutrition
Green – Other
ATTACH FLAG HERE

Child's Last Name_____ Child's First Name_____ MI____

Street Address_____ City_____ State_____ Zip_____

Mailing Address (if different) _____ City_____ State_____ Zip_____

Primary Phone # (home/cell) _____ Alternate Phone # (cell/work/message/emergency)_____

HOUSING: ❑Own or Buying ❑Renting ❑Homeless (complete back page) ❑Other explain _____(complete back page)

FAMILY TYPE: ❑Female single parent ❑Male single parent ❑Two parent Household

Total # of Household Members: _____ #of children _____ By age: 0-3____ 4-5 ____

Veteran in Family (indicate family member) _____ **Native language if other than English:**_____

HOUSEHOLD MEMBERS ***(including yourself; If more than 5 members please continue on the back of this form)***

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability Y or N	Medical Insur.
Primary Adult					Yes No					
Secondary Adult or Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					

Codes

Education Level
COL-College/Advanced Training
CTG-Training Cert.
HSG-High School Grad
GED-General Education Diploma
G9-Grade 9 or less
G10-Grade 10
G11-Grade 11
G12-Grade 12

Employment Status
F-Full Time (28+hrs/wk)
P-Part Time
R-Retired or Disabled
T-Training or School
B-Full Time & Training
L-Part Time & Training
S-Seasonally Employed
U-Unemployed

Medical Insurance
XIX
Hawk-I
Private
None
Other

INCOME SOURCES

****Proof of Income will be required to process application**

Income received in the last year (check all that apply)

	Primary Adult	Secondary Adult
Work	❑	❑
SSI	❑	❑
Social Security	❑	❑
FIP/TANF	❑	❑
Unemployment	❑	❑
Scholarships	❑	❑
Grants	❑	❑
Child Support	❑	❑
Other (explain)	❑_____	❑_____

Emergency Contacts

(Other than parents)

#1
Name: _____Relationship _____
Address: _____
City/State/Zip_____
Phone: H/C/M/W: ( )_____
Emergency Contact? ❑Yes ❑No
Release To? ❑Yes ❑No

#2
Name: _____Relationship _____
Address: _____
City/State/Zip_____
Phone: H/C/M/W: ( )_____
Emergency Contact? ❑Yes ❑No
Release To? ❑Yes ❑No

Doctor:

Name_____ Phone: _____
Address:_____ City:_____ State:_____

Dentist:

Name_____ Phone: _____
Address:_____ City:_____ State:_____

Hospital Preference: _____ Phone: _____
Address:_____ City:_____ State ____

I have carefully reviewed the information in this form and by signing this application, certify to the best of my knowledge and belief that all information in this application is true and correct. I further understand that this is an application for services that are paid with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in dis-enrolling my child from Head Start Early Head Start and is considered fraud and could have serious legal consequences for me.

Parent/Guardian signature: X_____ Date: _____

Verifying Staff Member: X_____ Date: _____

APPLICANT'S NAME:_____

ADDITIONAL HOUSEHOLD MEMBERS

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability Y or N	Medical Insur.
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					

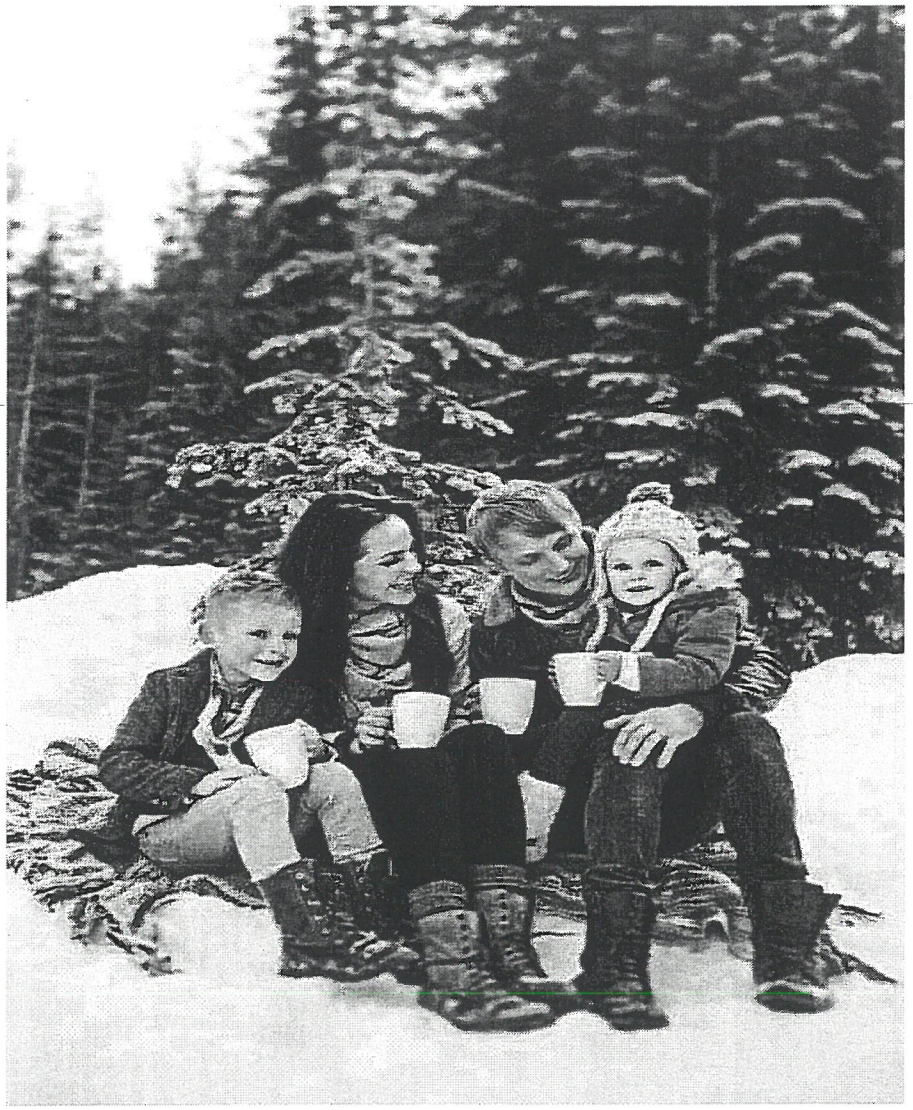
Codes

Education Level		Employment Status		Medical Insurance	
COL-College/Advanced Training	G9-Grade 9 or less	F-Full Time (28+hrs/wk)	B-Full Time & Training	XIX	Other
CTG-Training Cert.	G10-Grade 10	P-Part Time	L-Part Time & Training	Hawk-I	
HSG-High School Grad	G11-Grade 11	R-Retired or Disabled	S-Seasonally Employed	Private	
GED-General Education Diploma	G12-Grade 12	T-Training or School	U-Unemployed	None	

I have carefully reviewed the information in this form and by signing this application, certify to the best of my knowledge and belief that all information in this application is true and correct. I further understand that this is an application for services that are paid with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in dis-enrolling my child from Head Start Early Head Start and is considered fraud and could have serious legal consequences for me.

Parent/Guardian signature: **X**_____ Date: _____

Verifying Staff Member: **X**_____ Date: _____



Don't get left out in the cold!

Continuous Coverage for Hawki and Medicaid Members ends April 1.

Make sure your contact information for Medicaid/Hawki is correct. If it is not, you may miss important mailing or calls and lose your coverage.

Have up to date information **Watch for mail from Iowa Medicaid**

Respond to requests for information

Iowa Medicaid 800-338-8366

imememberservices@dhs.state.ia.us