

Please return this form to:

EOPS/CARE Office
 Barstow College
 2700 Barstow Road
 Barstow, CA 92311

Name of Financial Aid Applicant (please print)		
Last	First	Middle
Social Security No. _____		

Untaxed Income Verification - Agency Certification

Federal and state regulations relative to student financial aid mandate coordination and verification of all family financial resources. The information provided below will be used only to determine financial aid eligibility and will be kept confidential by the campus pursuant to Sections 76200-76246 of the California Education Code and the 1974 Family Education Rights and Privacy Act.

TO BE COMPLETED BY STUDENT AND SPOUSE, IF APPLICABLE, AND/OR PARENT BEFORE SUBMITTING TO AGENCY

I authorize the appropriate office/agency to provide the information requested by the school listed above.

Case Name (benefit recipient)		Case Number	
Applicant's Signature	Date	Mother's Signature*	Date
Applicant's Spouse's Signature	Date	Father's Signature+	Date
*Mother's Social Security No. _____		+Father's Social Security No. _____	

TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS AND RETURNED TO OFFICE LISTED AT TOP LEFT

Case Name (benefit recipient)		Case Number	
The student named above <input type="checkbox"/> IS receiving benefits for him/herself <input type="checkbox"/> IS NOT receiving benefits for him/herself <small>(Ex: student sanctioned, receiving for child(ren) only)</small>			
Recipient's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single			
Number of adults in household _____		Number of dependent children in household _____	
Benefits received:	Total 2007 1-1-07 to 12-31-07	Current Monthly Amount	
•Type of Benefit: _____ (for entire family, including applicant) Benefits began: _____ (Month/Year)	\$ _____	\$ _____	
•Type of Benefit: _____ (for entire family, including applicant) Benefits began: _____ (Month/Year)	\$ _____	\$ _____	
•Type of Benefit: _____ (for entire family, including applicant) Benefits began: _____ (Month/Year)	\$ _____	\$ _____	
Is change or termination of benefit(s) anticipated during the year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain change or give date of information: _____			
Is an allowance provided to cover educational costs (fees, books, child care, transportation, supplies, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Agency Representative	Title/Official Position
Signature	Date
Phone Number _____	

AGENCY STAMP REQUIRED