

RETURN TO:

San Jose City College
EOP&S Department
2100 Moorpark Ave.
San Jose, CA 95128-2799
(408) 288-3799

Name of Financial Aid Applicant <i>(Please print)</i>		
Last	First	Middle
Social Security Number: _____ - _____ - _____		

AGENCY CERTIFICATION—UNTAXED INCOME

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 THE STUDENT AND SPOUSE, IF APPLICABLE, AND/OR PARENT BEFORE SUBMITTING TO AGENCY <i>I authorize the appropriate office/agency to provide the information requested by the school listed above.</i>	
Case Name under which benefits are paid <i>(Please print)</i>	Case Number
Applicant's Signature _____ Date _____	Mother's Signature _____ Date _____ Social Security Number: _____ - _____ - _____
Applicant's Spouse's Signature _____ Date _____	Father's Signature _____ Date _____ Social Security Number: _____ - _____ - _____
<input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> General Relief <input type="checkbox"/> Social Security Benefits <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Veteran's Contributory Benefits <input type="checkbox"/> Pension Benefits <input type="checkbox"/> Cal Works <input type="checkbox"/> Federal/State Disability Benefits <input type="checkbox"/> Housing Authority (HUD) <input type="checkbox"/> Other: _____	

TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS		
<input type="checkbox"/> The person(s) named above received/receives no assistance from this agency <input type="checkbox"/> No record <input type="checkbox"/> Not eligible (<i>Reason</i>) _____		
Benefits received are listed below	Total 2007 Jan. 1, 2007–Dec. 31, 2007	Current Monthly Amount
<ul style="list-style-type: none"> • Type of benefit Cash Aid <input type="checkbox"/> Entire family <input type="checkbox"/> Dependent only <input type="checkbox"/> \$ _____ \$ _____ Food Stamps <input type="checkbox"/> Med-ical <input type="checkbox"/> 		
Case Number: _____		
Is applicant considered a single parent? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is there a change or termination of benefit(s) anticipated during the year? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain change or give date of information: _____		
Is an allowance provided to cover fees, transportation, books, and supplies? Yes <input type="checkbox"/> No <input type="checkbox"/> Itemize allowance(s) and give amount(s): _____		

Agency Representative <i>(type or print)</i> _____	Title/Official Position _____
Signature _____	Date _____
() _____	
Telephone Number _____	

**AGENCY STAMP
REQUIRED**