

2010-2011

RETURN TO:
San Jose City College
EOP&S Office
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 2009	Current	
	Jan. 1, 2009–Dec. 31, 2009	Monthly Amount	
• Type of benefit:			
Cash Aid Yes No	\$ _____	\$ _____	
Food Stamp Yes No			
Medical Yes No			
For entire family, including applicant:			
Benefits began: _____ / _____	\$ _____	\$ _____	
	Month/Year		
Case Number: _____			
Is the applicant considers single head of household? Yes No			
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 fees, transportation, books, and supplies? Yes No
Itemize allowance(s) and give amount(s): _____

Agency Representative (*type or print*)

Title/Official Position

Signature

Date

(_____) _____

Telephone Number

AGENCY STAMP REQUIRED