

2003-2004

Return to: **EOP&S L-107**

Name of CARE applicant (please print)

Pasadena City College
1570 E. Colorado Blvd.
Pasadena, CA 91106

Last _____ First _____ M. _____

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 CARE eligibility and will be kept confidential by the campus pursuant to Sections 76200-76246 of the California Educational Code and the 1974 Family Education Rights and Privacy Act.

To be completed by student, spouse, and/or parent before submitting to agency: I authorize the appropriate office/agency to provide the information requested by the college listed above.

Case Name under which benefits are paid _____

Case Number _____

Applicant's Signature _____

TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS:

The person(s) named above received/receives no assistance from this agency.

No Record Not Eligible _____
(Reason)

Recipients benefits are listed below:	Total 2002 1/1/2002-12/31/2002	Current Monthly Amount
Type of benefit: _____		
For entire family, including applicant	\$ _____	\$ _____

Date benefits began: _____
Month Year

Number of person(s) currently receiving benefits: Adults: _____ Children: _____

Number of children **under** the age of fourteen years: _____

Is a change or termination of benefit(s) anticipated during the year? Yes No
If yes, explain change or give date of termination:

Agency Representative (type or print) _____

Title/Official Position _____

Signature _____ Date _____

Agency Address _____

Telephone Number _____

AGENCY STAMP REQUIRED