**PLEASE RETURN THIS COMPLETED FORM VIA EMAIL TO: WLAC-CARE@LACCD.EDU**
WEST LOS ANGELES COLLEGE
EOPS/CARE PROGRAM

For care office use only
Received by: _____
Date: _____ Time: _____
_____
CARE Eligibility Approval Signature
Date:_____

# UNTAXED INCOME VERIFICATION-AGENCY CERTIFICATION

EOPS and CARE regulations require us to verify your household's financial resources. The information provided below will be used only for the purpose of determining EOPS and CARE eligibility and will be confidential per Section76200-76246 of the California Education Code and the 1974 Family Education Rights and Privacy Act.

## TO BE COMPLETED BY STUDENT BEFORE SUBMITTING TO AGENCY

I Authorize the appropriate office/agency to provide the information requested by West Los Angeles College.

Case Name under which benefits are paid: _____

CARE Applicant's Signature_____ Date_____

## TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS

**ELIGIBILITY FOR CARE IS LIMITED TO SINGLE HEADS OF HOUSEHOLDS WHO ARE CURRENTLY RECEIVING TANF/CalWORKs

**1. The person named above does NOT receive assistance from this agency:** (please indicate below)
**No Record_____ Not Eligible_____ (reason) _____**

**2. The recipient CURRENTLY receives benefits as listed below:** (please fill in the blanks unless stated otherwise)

a) Type of benefit: _____ Date benefits began: _____

b) TANF/CalWORKs duration: _____ Cash grant for CalWORKs: $_____

c) Cash grant to pay for CHILDCARE EXPENSES while attending classes at WLAC? YES NO

d) Amount of childcare economic assistance per month: $_____ (Disregard if no monetary assistance is provided)

e) Economic assistance to pay for childcare expenses is paid for: (Disregard if no monetary assistance is provided)
Class Attendance_____ Employment/Training_____ Other_____

**3. Is the student identified as a Single Parent Head of Household by your agency?** YES NO

**4. Is a change of termination of benefit anticipated during this year?** YES NO

_____
Name and Title of Agency Representative

_____
Signature Date

Telephone and Fax Numbers_____

**AGENCY STAMP REQUIRED**

**Name of CARE Applicant_____ SID#_____**