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

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#_____