

RETURN TO:

Shawna Luce / CalWORKs Program Coordinator
510-659-6159 FAX
CalWORKs Office, Bldg. 7 Room 7247
43600 Mission Blvd. Fremont, CA 94539



Name of CalWORKs Recipient (*Please print*)

Last _____ **First** _____

Student ID Number _____

Semester : Fall 2009

VERIFICATION OF ELIGIBILITY FOR CARE AND CALWORKS

State regulations relative to student CARE and CalWORKs Program participation mandate verification of eligibility. The information provided below will be kept confidential by the campus.

To Be Completed by the student *BEFORE* submitting to the agency.

I authorize the appropriate office/agency to provide information requested by the school listed above.

Student Name (PRINTED)

Social Security Number

Student Signature

Date

To be completed by the agency providing benefits

- The participant named above receives assistance from this agency
- The participant named above is in good standing with this agency
- The participant named above is NOT receiving assistance BUT has at least one child who IS receiving aid from this agency
- NO record of the participant named above

Is this a **ONE** parent or **TWO** parent household? _____

Number of people on the case _____

Active Case Number _____

Agency Representative (PRINT)

Title/Official Position

Signature

Date

AGENCY STAMP REQUIRED