

**RETURN TO:**

Shawna Lujan / CalWORKs Program Coordinator  
510-659-6159 FAX  
CalWORKs Office  
43600 Mission Blvd. Fremont, CA 94539



Name of CalWORKs Recipient ( <i>Please print</i> )	
<b>Last</b>	<b>First</b>
Student ID Number _____	
Semester : _____	

**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.

<b>To Be Completed by the student <i>BEFORE</i> submitting to the agency.</b>	
<i>I authorize the appropriate office/agency to provide information requested by the school listed above.</i>	
_____	_____
Student Name (PRINTED)	Social Security Number
_____	_____
Student Signature	Date

<b><i>To be completed by the agency providing benefits</i></b>	
<input type="checkbox"/> The participant named above receives assistance from this agency <input type="checkbox"/> The participant named above is in good standing with this agency <input type="checkbox"/> The participant named above is NOT receiving assistance BUT has at least one child who IS receiving aid from this agency <input type="checkbox"/> NO record of the participant named above	
Is this a <b>ONE</b> parent or <b>TWO</b> parent household? _____	
Number of people on the case _____	
Active Case Number _____	

_____	_____
Agency Representative (PRINT)	Title/Official Position
_____	_____
Signature	Date

<b><u>AGENCY STAMP REQUIRED</u></b>
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