CARE NEW STUDENT APPLICATION
PACKET for 2017-2018

TO: All Potential CARE Students

If you plan to attend Allan Hancock College and apply to the CARE (Cooperative Agencies Resources for Education) program, please refer to the following checklist below to assist you. If you have any questions, please do not hesitate to call or stop by my office.

Alex Spiess, CARE/CAFYES Program Coordinator
805-922-6966, ext. 3623 Building A, Room 203

- Obtain EOPS Application. Complete and submit EOPS application as soon as possible to the CARE Center. Follow all guidelines outlined in EOPS checklist. Complete the on-line Free Application for Federal Student Aid (FAFSA), at www.fafsa.ed.gov and submit a Board of Governor’s Fee Waiver form (BOG/FW) to the Financial Aid Department.

- Complete pages 1 & 2 of CARE application. Submit to the CARE Center in building A, room 203.

- Complete page 3 of CARE application “CARE Grant Selection Form”. If you receive any assistance from another agency or program for child care (i.e., CalWORKs, CAC, SBCEO) you will check the box marked “CARE Educational Grant.” If you do not receive any assistance for child care please check the box for “CARE Child Care Grant” and complete both sections A and B. Please note that a provider signature is required. In order to qualify for the CARE program you must have at least one child under the age of 14.

- Submit a print-out of your cash aid assistance or take page 4 “Agency Certification” to your CalWORKs worker. You may have your worker mail the form back to us, or you can walk the completed form to the CARE Center. In order to expedite your application process, we also accept a recent Notice of Action, or a twelve-month (or less) print-out from the Department of Social Services.
CARE- Cooperative Agencies Resources for Education
NEW STUDENT APPLICATION FOR 2017-2018 ACADEMIC YEAR

Name of Applicant (please print) __________________________

AHC Student ID # __________________________

Street Address ____________________________

myHancock E-Mail Address ____________________________

City ____________________________

State ____________________________

Zip Code ____________________________

Phone Number ____________________________

Marital Status (You must circle One)

Single  Divorced  Widowed  Separated  Married

YES  NO

Are you Head of Household?

Have you applied for Financial Aid for 2017-2018?

Have you applied for EOPS at Allan Hancock College for 2017-2018?

Do you receive CalWORKs benefits? (If yes, date benefits began)____

Have you been referred to Allan Hancock College by Welfare to Work?

Are your child care expenses paid by another agency or grant?

If YES: Name __________________________________________

Do you require child care in order to attend classes at AHC?

Do you pay a portion of your child care expenses with your own resources?

Please list ALL your dependent children:

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CERTIFICATION:

ALL APPLICANTS: READ THIS STATEMENT AND SIGN BELOW

I hereby swear or affirm, under penalty of perjury, that all information on this form is true and complete to the best of my knowledge. I also realize that any false statements or failure to give proof when asked may be cause for the denial, reduction, withdrawal, and/or repayment of my grant. I authorize release of information regarding this application between the college district, Chancellor’s Office, California Community Colleges, Department of Social Services, and State Department of Rehabilitation.

___________________________________  ________________________
Applicant’s Signature      Date
Name of Applicant (please print)  

H Number

In order to remain eligible for the CARE program, I agree to:

- Be in compliance with EOPS regulations.
- Notify the CARE Program Coordinator before making changes to my class schedule, residence or phone number.
- Attend the CARE/CalWORKs Orientations for fall and spring semester.
- Provide new proof of cash aid assistance at the beginning of each semester.
- Meet with CARE Program Coordinator at least once during each semester.
- Meet with the EOPS/CARE counselor twice each semester to discuss progress and plan a schedule for next semester.

I understand that the child care funding amount will be recalculated each semester based on my class schedule.

I authorize Allan Hancock College to verify any of the child care information I have provided.

Signature of Applicant  Date

CARE Staff Signature  Date
CARE- Cooperative Agencies Resources for Education
Grant selection for 2017-2018
Please check the box for the grant of your choice (you may have either/or)

☐ CARE Educational Grant
This grant is for the following educational costs: textbooks, child care, uniforms, school supplies, transportation, and/or other educational expenses necessary for course completion. Please be advised that you may need to provide your Welfare-to-Work case manager with documentation (receipts) that your CARE Educational Grant was used for such services.
PRINT YOUR NAME: _______________________________             H# ______________
Signature of Applicant: _______________________________ Date: ____________

☐ CARE Child Care Grant (You must complete both section A and B for this grant)
This grant is for the purpose of child care costs in which you need to attend classes, college work-study hours, travel time to and from college, mandatory lab hours, and approved study time. Do not report hours paid by another agency.

Section A: Complete the chart

<table>
<thead>
<tr>
<th>Day of the week</th>
<th>Time In</th>
<th>Time Out</th>
<th>Activity</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section B: Please list the name(s), age(s), and birthdate(s) of child(ren) under the age of fourteen (14) requiring child care:
Name: _______________________________ Birthdate _____________ Age ______
Name: _______________________________ Birthdate _____________ Age ______
Name: _______________________________ Birthdate _____________ Age ______
Name: _______________________________ Birthdate _____________ Age ______
PRINT YOUR NAME: _______________________________ H# ______________
Signature of Applicant: _______________________________ Date: ____________

PROVIDER STATEMENT
You must have your child care provider complete this section of the form------
I will be caring for the child (ren) listed above during the hours indicated. I am currently charging this student $________ per hour/day.

Name of Provider (please print) _______________________________ Provider ID # (Optional) _______________________________
Street Address ____________________________________________ Signature of Provider Date _______________________________
City __________________ State ________ Zip __________________ Phone Number ______________________________

If you select “CARE Child CARE Grant” please ensure that this form is filled out completely; incomplete forms will not be processed for a grant.
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 financial aid eligibility and will be kept confidential by the campus pursuant to Section 76200-76246 of the California Education Code and the 1974 Family Education Rights and Privacy Act.

TO BE COMPLETED BY THE STUDENT AND SPOUSE, IF APPLICABLE, AND/OR PARENT BEFORE SUBMITTING TO AGENCY.

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

<table>
<thead>
<tr>
<th>Case name under which benefits are paid (please print)</th>
<th>Case Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant's Signature</td>
<td>Date</td>
</tr>
<tr>
<td>TANF/CalWORKs</td>
<td>Veteran's Benefits</td>
</tr>
<tr>
<td>Fed /State/Other</td>
<td>Disability</td>
</tr>
<tr>
<td>Housing Authority</td>
<td>Voc. Rehab</td>
</tr>
<tr>
<td>Vet.’s Education Benefits</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS

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

<table>
<thead>
<tr>
<th>Benefits received are listed below:</th>
<th>Current Monthly Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Type of benefit: ________________________________</td>
<td>$ ______________</td>
</tr>
<tr>
<td>For entire family, including applicant: ...............</td>
<td></td>
</tr>
<tr>
<td>Benefits Began (Month/Year): __________________________</td>
<td></td>
</tr>
<tr>
<td>*Type of benefit: ________________________________</td>
<td>$ ______________</td>
</tr>
<tr>
<td>For entire family, including applicant: ...............</td>
<td></td>
</tr>
<tr>
<td>Benefits Began (Month/Year): __________________________</td>
<td></td>
</tr>
<tr>
<td>Is change or termination of benefit(s) anticipated during the year?</td>
<td>YES</td>
</tr>
<tr>
<td>If yes, explain change or give date of termination: ________________________________</td>
<td></td>
</tr>
<tr>
<td>Is an allowance provided to cover CHILD CARE, fees, transportation, books, and supplies?</td>
<td>YES</td>
</tr>
<tr>
<td>Itemize allowance(s) and give amount(s): ________________________________</td>
<td></td>
</tr>
</tbody>
</table>

Agency Representative (type or print) | Title/Official Position

Signature | Date

Telephone Number: (______) ____________________________

AGENCY STAMP REQUIRED