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.

ALLAN HANCOCK COLLEGE
800 SOUTH COLLEGE DRIVE
SANTA MARIA CA 93454
(805) 922-6966 EXT. 3623

CARE- Cooperative Agencies Resources for Education
NEW STUDENT APPLICATION FOR 2017-2018 ACADEMIC YEAR

_____ **H**_____
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:

Full Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

ALLAN HANCOCK COLLEGE
800 South College Drive
Santa Maria, CA 93454
(805) 922-6966 ext. 3623

2017-2018
CARE Student Agreement

_____ _____
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

Day of the week	Time In	Time Out	Activity	Total Hours
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

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.

2017-2018

RETURN TO

ALLAN HANCOCK COLLEGE
EOPS/CARE DEPARTMENT
800 South College Drive
Santa Maria, CA 93454-6399
(805) 922-6966, Ext. 3623

Name of **CARE** Applicant (please print)

_____
Last First Middle

H#: _____

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.

_____ _____
Case name under which benefits are paid (please print) Case Number

_____
Applicant's Signature Date

TANF/CalWORKs	Veteran's Benefits	Supplemental Security	GAIN
Fed /State/Other	Disability	General Relief	Vet.'s Cont. Benefits
Housing Authority	Voc. Rehab	Unemployment Benefits	Social Security Benefits
Vet.'s Education Benefits		Refugee Cash Assistance	Pension Benefit
Other_____			

TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS

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

No record Not eligible (Reason) _____

Benefits received are listed below: **Current Monthly Amount**

***Type of benefit:** _____
For entire family, including applicant: . . . . . . $_____
Benefits Began (Month/Year): _____

***Type of benefit:** _____ $_____
For entire family, including applicant: . . . . . .
Benefits Began (Month/Year): _____

Is change or termination of benefit(s) anticipated during the year? YES NO
If yes, explain change or give date of termination: _____

Is an allowance provided to cover CHILD CARE, fees, transportation, books, and supplies? YES NO
Itemize allowance(s) and give amount(s): _____

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

_____ _____
Signature Date
Telephone Number: (_____)_____

AGENCY STAMP REQUIRED