



# CARE Supplemental Application

Name \_\_\_\_\_ DOB \_\_\_\_\_ Student ID# \_\_\_\_\_  
First Middle Last Date of Birth

Campus: EKA KT DN Contact Information: ( ) \_\_\_\_\_  
Phone Number Social Security Number

**CARE** (Cooperative Agencies Resources for Education) is a supplemental program for EOPS eligible students who are single-head of household with a household family member who is a recipient of CalWORKs/TANF/Tribal TANF, and have a child who is under eighteen years of age. If you are eligible for the CARE Program, you may receive benefits that are in addition to those you receive from EOPS.

I am receiving benefits from:

- CalWORKs  
 Worker Name \_\_\_\_\_  
 Worker Phone # \_\_\_\_\_
- Tribal TANF  
 Agency Name \_\_\_\_\_  
 Worker Name \_\_\_\_\_  
 Worker Phone # \_\_\_\_\_
- Social Security (SSI)

**Marital Status (please circle one)**

U = Unmarried D = Divorced S = Separated W = Widowed MA = Married (Spouse Absent)

Family Status		List all family members that currently live with you.		
Name	Relationship	Dependent	Age	Birth Date
	<i>Yourself</i>	<i>Circle Yes or No</i>		
		<b>Yes/No</b>		
		<b>Yes/No</b>		
		<b>Yes/No</b>		
		<b>Yes/No</b>		
		<b>Yes/No</b>		
		<b>Yes/No</b>		

CERTIFICATION

**All applicants must read this statement and sign below.**

I certify, under penalty of perjury, that all information on this form is true and complete to the best of my knowledge. I authorize release of information regarding this application between the college, the college district, the CR CalWORKs Office, the California Community Colleges Chancellor's Office, County Social Service Agencies, and Tribal TANF agencies.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

This form will expire one year after signature date.