



# Financial Aid Office

El Camino College (ECC) - 16007 Crenshaw Blvd. ♦ Torrance, CA 90506 ☎ 1-310-660- 3493 ♦ www.elcamino.edu  
ECC Compton Center (COM) - 1111 E. Artesia Blvd., E-17 ♦ Compton, CA 90221 ☎ 1-310-900-1600 x 2935 ♦ www.compton.edu

## 2017-2018 Agency Certification Form (Untaxed Income)

Print all information neatly in black or blue ink.

If any item does not apply, enter "N/A" for Not Applicable where a response is requested, or enter 0 in an area where an amount is requested.

El Camino College Student ID Number		Last 4 Digits of Social Security Number		Date of Birth (MM/DD/YYYY)	
Last Name		First Name		Middle Name	
Address (Number & Street)		City	State	Zip Code	Telephone Number

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 college pursuant to Sections 76200-76246 of the California Education Code and the Family Educational Rights and Privacy Act (FERPA).

<b>TO BE COMPLETED BY THE STUDENT AND SPOUSE, IF APPLICABLE, AND/OR PARENT BEFORE SUBMITTING TO AGENCY</b>					
<i>I authorize the appropriate office/agency to provide the information requested by the school listed above.</i>					
Case Name under which benefits are paid (Please print)			Case Number		
Applicant's Signature		Date		Parent 1 Signature	
				Date	
				Social Security Number: _____-_____-_____	
Applicant's Spouse's Signature		Date		Parent 2 Signature	
				Date	
				Social Security Number: _____-_____-_____	
<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> General Relief	<input type="checkbox"/> Social Security Benefits			
<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Unemployment Benefits			
<input type="checkbox"/> Veteran's Contributory Benefits	<input type="checkbox"/> Pension Benefits	<input type="checkbox"/> CalWORKs			
<input type="checkbox"/> Federal/State Disability Benefits	<input type="checkbox"/> Housing Authority (HUD)	<input type="checkbox"/> Other: _____			

### TO BE COMPLETED BY THE AGENCY PROVIDING BENEFITS

<input type="checkbox"/> The person(s) named above received/receives no assistance from this agency	
<input type="checkbox"/> No record <input type="checkbox"/> Not eligible (Reason) _____	
Benefits received are listed below	<u>CURRENT MONTHLY AMOUNT</u>
• 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain change or give date of information: _____	
Is an allowance provided to cover fees, transportation, books, and supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Itemize allowance(s) and give amount(s): _____	

_____	_____
<b>Agency Representative (Type or print)</b>	<b>Title/Official Position</b>
_____	_____
<b>Signature</b>	<b>Date</b>
(_____) _____	
<b>Telephone Number</b>	

AGENCY STAMP REQUIRED