COOPERATIVE AGENCIES RESOURCES FOR EDUCATION

San Diego City College EOPS Program
1313 Park Blvd, Bldg. A - Room 354 San Diego CA 92101
Office (619) 388-3209 ~ Fax (619) 388-3163

2022-2023
CARE PROGRAM APPLICATION

CSID#:______________________________ County Case#: ____________________________

Name:____
LAST FIRST

Address:____
STREET CITY STATE ZIP

Email Address:____Primary Phone#: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Answer each questions as it pertains to YOU. You must answer YES to each question to be eligible for CARE.

☐ Yes ☐ No I am currently participating or have applied to the San Diego City College EOPS Program.
☐ Yes ☐ No I am a parent or legal guardian of at least one child under the age of 18.
☐ Yes ☐ No I am currently receiving CalWORKs cash aid assistance for myself and/or my dependent children.
☐ Yes ☐ No I am designated as single head of household by the County HHSA.
☐ Yes ☐ No I reside in a one-parent household.
☐ Yes ☐ No I am at least 18 years of age or older.

PLEASE LIST YOURSELF AND YOUR DEPENDENT CHILDREN (*and other dependents in your household if they will receive more than half of their support from you). If applicable include your spouse and/or the parent of your children if they reside in your household*.

FULL NAME	AGE	BIRTHDATE	RELATIONSHIP

CERTIFICATION

By typing my name below, I certify under penalty of perjury, that all information on this form is true and complete to the best of my knowledge. I also understand that false statements may result in cancellation of program services and participation. I also grant permission for CARE staff to verify information on this form utilizing the San Diego County CALWIN System.

____ ___________________________________
Student Signature Date

OFFICE USE ONLY

EOPS ELIGIBLE: ☐YES ☐NO CARE ELIGIBLE: ☐YES ☐NO DATE:__________STAFF INT: ______

COMMENTS: ____