Student's Name _____ GCC ID# _____

FINANCIAL AID OFFICE

# 2013-2014 UNTAXED INCOME VERIFICATION FORM

**INSTRUCTIONS:** Section A must be completed by the person whose name appears on the case before submitting the form to their caseworker. A separate Untaxed Income Verification form must be completed for **each** case and type of untaxed income. Below, check the type of assistance received (such as TANF, General Relief). Section B must be completed by the caseworker of the agency providing benefits. If any part of this form is left blank, it will not be accepted.

## SECTION A: TO BE COMPLETED BY THE PERSON RECEIVING THE BENEFIT

*I authorize the appropriate office/agency to provide the information requested by the Financial Aid Office at Glendale Community College for the benefit indicated below.*

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

Relationship of Recipient to student _____

Signature of RECIPIENT _____

☐☐☐–☐☐–☐☐☐☐
Social Security Number of RECIPIENT

- ☐ TANF/Cal Works
- ☐ General Relief
- ☐ Supplemental Security Income
- ☐ Food Stamps/SNAP
- ☐ Social Security Benefits
- ☐ CAPI
- ☐ Federal/State Disability Benefits
- ☐ Refugee Cash Assistance
- ☐ Other_____

## SECTION B: TO BE COMPLETED BY THE AGENCY PROVIDING THE BENEFIT

Federal and State regulations relative to student financial aid **require** 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 Financial Aid Office at Glendale Community College pursuant to Sections 76200-76246 of the California Education Code and the 1974 Family Education Rights and Privacy Act.

**The person named above in Section A received/receives no assistance from this agency.**

☐ No Record

☐ Not Eligible (Reason) _____

| **The person named above in Section A received cash benefits as follows:** | 2012 Total Cash Received 1/1/2012 – 12/31/2012 | Current Monthly Amount |
|---|---|---|
| • Type of Benefit _____ | $_____ | $ _____ |
| Benefits began _____ Month / Year | | |
| • Type of Benefit _____ | $_____ | $ _____ |
| Benefits began _____ Month / Year | | |

Agency Representative (**PLEASE PRINT FULL NAME**) _____

Title/Official Position _____

Signature of Agency Representative _____

**AGENCY STAMP REQUIRED**

Date _____ Telephone Number _____