

NEW STUDENT APP INTAKE FORM

ID # _____ LAST NAME, FIRST NAME MI _____

ELIGIBLE
EOPS VOUCHER #

DATE SUBMITTED _____ FOR 20__/FA 20__/WI 20__/SP 20__/SU

ELIGIBLE
CARE VOUCHER #

OTHER COHORTS: _____ RET. FROM: _____

TEST SCORES: _____

ECC DEG-APP UN: _____ + CCC DEG-APP UN: _____ = _____

OTHER SCHOOL: _____ - DEG-APP UN: _____

OTHER SCHOOL: _____ - DEG-APP UN: _____

OTHER SCHOOL: _____ - DEG-APP UN: _____

OTHER SCHOOL: _____ - DEG-APP UN: _____

FILE STATUS:
 COMPLETED APP.
 SIGNED MRC
 SIGNED BK VCHR
RELEASE FORM
 CURRENT ED PLAN

TOTAL: _____

EOPS/CARE ELIGIBILITY: A B C D E: _____

PROBLEM

	ELIGIBLE	PROBLEM	INELIGIBLE
--	----------	---------	------------

EOPS			
Units for term (min. 4 un. for Sum.)	<input type="checkbox"/> ≥ 12:	<input type="checkbox"/> 11.5-0.5:	<input type="checkbox"/> 0
STAL	<input type="checkbox"/> COM:	- - - - -	<input type="checkbox"/> Blank or End Date
AtP	<input type="checkbox"/> COM	<input type="checkbox"/> None	<input type="checkbox"/> ECC
Fin Aid Budget Location	<input type="checkbox"/> COM	<input type="checkbox"/> None	<input type="checkbox"/> ECC
70+ Degree-Applicable Units	<input type="checkbox"/> No	- - - - -	<input type="checkbox"/> Yes:
BOGFW	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C FC=0	<input type="checkbox"/> None	<input type="checkbox"/> C FC >0:
	<input type="checkbox"/> SBGMA FC=0	<input type="checkbox"/> SBGMA No FC	<input type="checkbox"/> SBGMA FC >0
	<input type="checkbox"/> SBGMB FC=0	<input type="checkbox"/> SBGMB No FC	<input type="checkbox"/> SBGMB FC >0
	<input type="checkbox"/> SBGMC FC=0	<input type="checkbox"/> SBGMC No FC	<input type="checkbox"/> SBGMC FC >0
Dream-Application Eligible	<input type="checkbox"/> Yes & Conf Pg Attached	<input type="checkbox"/> Yes & Conf Pg N/Attached	<input type="checkbox"/> No-AB540 Non- Dreamer

Evaluated & Certified by-Staff/Date:

INELIGIBLE-REASON

CARE			
Marital status	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> D <input type="checkbox"/> W	<input type="checkbox"/> N/marked on app	<input type="checkbox"/> M
Head of Household	<input type="checkbox"/> Y	<input type="checkbox"/> N/marked on app	<input type="checkbox"/> N
Current Verification of Benefits	<input type="checkbox"/> Yes-Duration:	<input type="checkbox"/> No <input type="checkbox"/> N/curr	<input type="checkbox"/> N/Ingr rcvs cash aid
Dep. birth cert. att.	<input type="checkbox"/> Yes-# of dep.:	<input type="checkbox"/> No	<input type="checkbox"/> No dependent(s)

Evaluated & Certified by-Staff/Date:

STAFF COMMENTS/PHONE LOG

2016/FALL

Date	Comments	Staff Initials