Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

STUDENT GRANT AND EXPENSE VERIFICATION

CASE NAME	CASE NUMBER
COMMUNITY SERVICES OFFICE (CSO)	DATE

SECTION 1: TO BE COMPLETED BY DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)

FINANCIAL SERVICES SPECIALIST NAME	TELEPHONE NUMBER

CLIENT NAME AND ADDRESS

SECTION 2: TO BE COMPLETED BY STUDENT

STUDENT NAME (PLEASE PRINT)	SOCIAL SECURITY NUMBER	NAME OF SCHOOL

Yo autorizo a la escuela mencionada arriba, a divulgar información sobre mis estudios a DSHS, el Departamento de Seguridad de Empleo (ESD), y la División de Rehabilitación Vocacional (DVR). Esta información incluye información sobre becas, gastos de educación, horas de crédito, información sobre asistencia y calificaciones. DSHS usará esta información para determinar precisamente la eligibilidad para Asistencia Pública y/o para estampillas de comida. Una copia de este formulario puede enviarse a ESD para determinar mi eligibilidad para fondos de los programas JOBS o FIP. Una copia de este formulario también se puede enviar a DVR para determinar mi eligibilidad para el programa de servicios de rehabilitación vocacional.

La escuela nesecita 10 días para completar este formulario. Usted debe incluir una copia de su beca financiera a este formulario y debe devolver la documentación a su Oficina de Servicios a la Comunidad. Debe mantener una copia para usted.

STUDENT SIGNATURE	DATE

SECTION 3: TO BE COMPLETED BY THE SCHOOL

Student is: ☐ Undergraduate; ☐ Graduate. Student attends: ☐ less than 1/2 time; ☐ 1/2 time or greater.

Period for which award and expenses cover: _____ (MONTH/YEAR) through _____ (MONTH/YEAR)

Award funds are issued each: ☐ Quarter ☐ Semester ☐ Other (Specify): _____

The following costs were used in budgeting the student's financial aid award. NOTE: Please consider the student's child care needs when establishing the financial aid need.

1. Total Financial Award:		$
2. Tuition and fees:	$	
3. Books and supplies:	$	
4. Transportation:	$	
5. Miscellaneous personal expenses:	$	
6. Sub-total Expenses: *(For ESD work programs)* **(Add lines 2 thru 5)**	$	
7. Dependent care expenses: *(For PA/FS programs)*	$	
8. Total Attendance Expenses: *(For PA/FS Programs)* **(Add lines 6 + 7)**	$	
9. Total Financial Award Available: *(For PA/FS Programs)* **(Subtract line 8 from line 1)**		$

FINANCIAL AID REPRESENTATIVE SIGNATURE	TELEPHONE NUMBER	DATE