EOPS/CARE Appeal

1100 N. Grand Avenue, Walnut, CA 91789 (**Please type or print legibly)**

Student Information:

Name:____
Last Name First Name Middle

Identification Number:_________________Phone Number:______________________

Major:____________________________________ [ ] EOPS [ ] CARE

Educational Goal (Check all that apply): [ ] Associate [ ] Transfer

Semesters Requesting Reinstatement (Check one):

[ ] Fall [ ] Winter [ ] Spring [ ] Fall, Winter and Spring

Reason for Disqualification (Check all that apply):

[ ] I did not comply with the following counseling contacts (check all that apply):

______ First Contact
______ Second Contact (Progress Report)
______ Third Contact

[ ] Other:____

Student Statement:

Explain the nature of the unusual or mitigating circumstances, describe how it prevented you from meeting the terms, conditions and follow-up provisions of the student Educational Plan and/or the EOPS/CARE Mutual Responsibility Contract. Include details and timelines. Explain the steps that you have taken to ensure that you understand and will adhere to all requirements as stated in the EOPS/CARE Mutual Responsibility Contract. Do not be vague; your Student Statement is required in evaluating the appeal. Please attach an additional sheet with supporting verification if applicable; be sure to include your name, student identification number, and signature.
All information submitted is confidential.

I agree to provide additional information if requested. I understand that regulations limit the period that I can regain eligibility. I agree to adhere to conditions of reinstatement specified. It is my responsibility to be aware and adhere to the terms, conditions, and follow-up provisions of the student Educational Plan and/or the EOPS/CARE Mutual Responsibility Contract to continue eligibility in the EOPS/CARE Program.

Signature:______________________________________Date:___________________