Useful Websites and Contact Information

FIND OUT ABOUT FINANCIAL AID

Student Aid on the Web

www.studentaid.ed.gov

At this U.S. Department of Education's Federal Student Aid website you can

- Find detailed information on Federal Student Aid programs; research school and career choices; learn about the entire federal student aid process, eligibility, and the application process; and access other Federal Student Aid websites and publications online.
- Create a "MyFSA" account, a federal student aid personalized folder to help you decide on a career, research schools, and find scholarships. Track your progress in the college planning and application process and access other sources of nonfederal aid.

APPLY FOR FINANCIAL AID

FAFSA on the Web℠

www.fafsa.gov

Apply for federal student aid online using *FAFSA on the Web*℠ (the online version of the *Free Application for Federal Student Aid*, or FAFSA℠.)

ACCESS YOUR FEDERAL LOAN RECORDS

National Student Loan Data System℠ (NSLDS℠)

www.nslds.ed.gov

Use your Federal Student Aid PIN to access your federal student loan records and obtain contact information on your loan servicer.

U.S. ARMED FORCES

www.studentaid.ed.gov/military

If you are in the armed forces or have a family member in the service, visit this site to find out more about grants, repayment, and forgiveness options.

REPORT STUDENT AID FRAUD

Office of Inspector General Hotline

www.ed.gov/misused

To report student aid fraud (including identity theft), waste, or abuse of U.S. Department of Education funds.

1-800-MIS-USED (1-800-647-8733)
E-mail: **oig.hotline@ed.gov**

CONTACT US

U.S. Department of Education
Federal Student Aid Information Center (FSAIC)

1-800-4-FED-AID (1-800-433-3243)
P.O. Box 84
Washington, DC 20044-0084

TTY users can call **1-800-730-8913.**
Callers in locations without access to 1-800 numbers may call **319-337-5665** (this is not a toll-free number).

The FSAIC staff will answer your federal student aid questions and provide you with:

- information about federal student aid programs,
- help completing the FAFSA,
- help making any corrections or updates to your FAFSA,
- help understanding your *Student Aid Report* (SAR), which contains your application results,
- information about the process of determining financial need and awarding aid, and
- general information about your current federal student loans.

You also can use an automated response system at the FSAIC to find out if your FAFSA has been processed and to request a copy of your *Student Aid Report* (SAR). Or you can write to the FSAIC.

State Higher Education Agencies

www.ed.gov/Programs/bastmp/SHEA.htm (case-sensitive)

List of agencies responsible for administering state financial aid programs.

If you paid for a copy of this FREE publication, please write to the FSAIC at the address above.

Table 1. Federal Student Aid: Type of aid, eligibility, award amount, interest rate

GRANTS AND WORK-STUDY		
Program	**Type of Aid**	**Eligibility (i.e., who can get the aid)**
Federal Pell Grant	Grant: does not have to be repaid	Available almost exclusively to undergraduates
Federal Supplemental Educational Opportunity Grant (FSEOG)	Grant: does not have to be repaid	For undergraduates with exceptional financial need; Federal Pell Grant recipients take priority; funds depend on availability at school
Teacher Education Assistance for College and Higher Education (TEACH) Grant	Grant: does not have to be repaid unless you fail to carry out the service obligation	For undergraduate, postbaccalaureate, and graduate students who are taking or will be taking coursework necessary to become an elementary or secondary school teacher; recipient must sign Agreement to Serve saying he or she will teach full-time in designate teacher shortage area for four complete years at elementary or secondary school serving children from low-income families
Iraq and Afghanistan Service Grant	Grant: does not have to be repaid	For undergraduate students who are not Pell-eligible; whose parent or guardian died as a result of military service in Iraq or Afghanistan after 9/11; and who, at the time of the parent's or guardian's death, were less than 24 years old or were enrolled at least part-time at an institution of higher education
Federal Work-Study	Money earned while attending school; does not have to be repaid	For undergraduate and graduate students; funds depend on availabili at school

LOANS		
Program	**Type of Aid**	**Eligibility (i.e., who can get the loan)**
Federal Perkins Loans	Loan: must be repaid with interest Interest rate: 5%	Undergraduate and graduate students Must demonstrate financial need; funds depend or availability at school
William D. Ford Direct Loans Direct Subsidized Loans	Loan: must be repaid with interest Interest rate: 6.8% (for loans first disbursed on or after July 1, 2012)	Undergraduate students enrolled at least half-time Must demonstrate financial need
Direct Unsubsidized Loans	Loan: must be repaid with interest Interest rate: 6.8%	Undergraduate and graduate students enrolled at least half-time Financial need is not required
Direct PLUS Loans (for parents and graduate and professional degree students)	Loan: must be repaid with interest Interest rate: 7.9%	Graduate students Parents of dependent undergraduate students whc are helping pay the cost of their child's education Financial need is not required; must not have adver credit history; must be enrolled at least half-time
Direct Consolidation Loans	Loan: must be repaid with interest Interest rate is fixed and based on the weighted average of the interest on the loans being consolidated, rounded up to the nearest one-eighth of 1% Interest rate: cannot exceed 8.25%	Borrowers with one or more federal student loans

How and when should I get a PIN?

You will be offered the option of getting one in real time when you fill out the online FAFSA. You can also apply for a PIN in advance at www.pin.ed.gov.

I can't remember my PIN.

You can request a duplicate PIN at www.pin.ed.gov. After you receive your duplicate PIN, you should return to the PIN site and use the "Change My PIN" function to choose a PIN you will be able to remember.

Safeguard your PIN!

- Your PIN is used to sign legally binding documents electronically and access your student aid records. It has the same legal status as a written signature.
- Don't give your PIN to anyone--not even to someone helping you fill out the FAFSA. Sharing your PIN could put you at risk of identity theft.
- Change your PIN to one you can easily remember if you think you might forget the one issued or think someone might know your PIN.

Table 5. Dependency Status

Answer these questions to find out if you are dependent or independent		
Were you born before Jan. 1, 1989?	Yes	No
Are you married? (Answer "Yes" if you are separated but not divorced.)	Yes	No
At the beginning of the 2012–13 school year, will you be working on a master's or doctorate degree (such as an M.A., M.B.A., M.D., J.D., Ph.D., Ed.D., graduate certificate, etc.)?	Yes	No
Are you currently serving on active duty in the U.S. armed forces for purposes other than training? If you are a National Guard or Reserves enlistee, are you on active duty for other than state or training purposes?	Yes	No
Are you a veteran of the U.S. armed forces?	Yes	No
Do you have children who will receive more than half of their support from you between July 1, 2012, and June 30, 2013?	Yes	No
Do you have dependents (other than your children or spouse) who live with you and who receive more than half of their support from you, now and through June 30, 2013?	Yes	No
At any time since you turned age 13, were both your parents deceased, were you in foster care, or were you a dependent or ward of the court?	Yes	No
Has it been decided by a court in your state of legal residence that you are an emancipated minor or that you are in a legal guardianship?	Yes	No
At any time on or after July 1, 2011, were you determined to be an unaccompanied youth who was homeless, as determined by (a) your high school or district homeless liaison or (b) the director of an emergency shelter or transitional housing program funded by the U.S. Department of Housing and Urban Development?	Yes	No
At any time on or after July 1, 2011, did the director of a runaway or homeless youth basic center or transitional living program determine that you were an unaccompanied youth who was homeless or were self-supporting and at risk of being homeless?	Yes	No

If you answered "No" to all of these questions, you're a dependent student. Go to www.fafsa.gov for more information.

Errata and Updates to *Funding Your Education: The Guide to Federal Student Aid*

The office of Federal Student Aid, U.S. Department of Education, is making the following correction to the 2012-13 edition of *Funding Your Education: The Guide to Federal Student Aid* (December 2011).

Page 14, Table 5. Dependency Status, the text below the table should read:

If you answered "No" to all of these questions, you're a dependent student. Go to **www.fafsa.gov** for more information.

The correction is reflected in the PDF version of the publication posted at **www.studentaid.ed.gov/pubs**, **www.studentaid.ed.gov/guide**, **www.FSAPubs.gov**, and **www.EDPubs.gov**. An image of the corrected page is enclosed for your reference.

There also have been recent changes in law that impact federal student aid programs and affect the content of *Funding Your Education: The Guide to Federal Student Aid*. The updated information appears below.

Eligibility of Students Without a High School Diploma

To be eligible for federal student aid, students enrolling in higher education for the first time on or after July 1, 2012, must have either a high school diploma or a recognized equivalent (such as a General Educational Development certificate [GED]) or have been homeschooled. Students will no longer have the option of becoming eligible for federal student aid by passing an approved test or completing at least six credit hours or 225 clock hours of postsecondary education.

Elimination of Grace Period Interest Subsidy

This provision eliminates the interest subsidy provided during the six-month grace period for Direct Subsidized Loans for which the first disbursement is made on or after July 1, 2012, and before July 1, 2014. Students receiving a subsidized loan during this timeframe will be responsible for the interest that accrues on the loan during the grace period. If a student does not pay the interest accrued, the interest will be added (capitalized) to the principal amount of their loan when the grace period ends.

For the most up-to-date information, go to our student site at **www.studentaid.ed.gov**.

January 2012

Generic Employment Application

Employer Name: Job Number:

Position: Date:

PERSONAL INFORMATION

Name (Last, First, Middle)	Telephone Number
Address	Message Number
City/State/Zip	E-mail Address

Are you legally authorized to work in the United States? ☐Yes ☐No		
Are You Applying For: ☐F/T ☐P/T ☐Temp	What Shift(s) Will You Work? ☐Days ☐Evenings ☐Nights	May We Contact Present Employer? ☐Yes ☐No

EMPLOYMENT HISTORY - Begin With Most Recent Employment

Dates From To	Company Name	City, State
Titles and Duties –		
Reason for Leaving:	Supervisor's Name	Telephone Number
Dates From To	Company Name	City, State
Titles and Duties –		
Reason for Leaving:	Supervisor's Name	Telephone Number
Dates From To	Company Name	City, State
Titles and Duties –		
Reason for Leaving:	Supervisor's Name	Telephone Number
Dates From To	Company Name	City, State
Titles and Duties –		
Reason for Leaving:	Supervisor's Name	Telephone Number

ILITARY - Branch of Service:

Describe any military training received relevant to the position for which you are applying:

DUCATION/TRAINING - Include Technical/Academic Achievements/Courses

Have you obtained a high school diploma or GED certificate? ☐Yes ☐No

School	Name & Location	Diploma/Degree	Subject Of Specialization
College/University			
Specialized Courses & Training			

LERICAL SKILLS - To Be Completed for Clerical Positions

Typing, WPM		Medical Terminology ☐Yes ☐No	Legal Terminology ☐Yes ☐No
Shorthand, WPM			

List Specific Computer Skills –

ROFESSIONAL & TECHNICAL INFORMATION - To Be Completed for Licensed/Registered Positions

Idaho Registration No.	Expiration Date	Certificate No.	Expiration Date
If not licensed in Idaho, have you applied? ☐Yes ☐No		If licensed in another state, list:	

THER SPECIAL SKILLS - List Other Specific Skills You Have to Offer for This Job Opening:

EFERENCES - Give the Names of Three Persons Not Related to You

Name	Address	Telephone	Occupation

he information on this application is true and accurate to the best of my knowledge.

gnature _____ Date _____

HE IDAHO DEPARTMENT OF LABOR DISTRIBUTES THIS FORM SOLELY FOR THE CONVENIENCE OF EMPLOYERS AND APPLICANTS, AND SCLAIMS ANY RESPONSIBILITY FOR THE MANNER IN WHICH THIS FORM IS COMPLETED OR USED IN THE HIRING PROCESS.

Employment Application

COMPANY OR EMPLOYER NAME: _____

Position applying for: _____

EMPLOYEE INFORMATION

Name: _____
Last First Middle

Telephone: _____ Email: _____ Alternate telephone: _____

Address: _____

Are you able to perform the essential functions of the position with or without accommodations?
☐ Yes ☐ No

If necessary for the job are you older than:
☐ 14 ☐ 15 ☐ 16 (Check one)
☐ 18 ☐ 19 ☐ 21

I am legally eligible for employment in the U.S.?
☐ Yes ☐ No

I am seeking a permanent position: ☐ Yes ☐ No

I will be able to report to work _____ days after being notified I am hired.

If necessary for the job, I am able to:

Work overtime? ☐ Yes ☐ No

Provide a valid Alaska Driver's License? ☐ Yes ☐ No

If so, fill out the following: Issuing state: _____

Type: _____

Endorsement(s): ☐ Hazardous Material ☐ Passengers ☐ Tankers ☐ Tank with Hazardous Materials ☐ School Bus ☐ Double/Triple trailers

Work the following shifts: (check all that apply)
☐ Any ☐ Day ☐ Night ☐ Swing ☐ Rotating
☐ Split ☐ Graveyard Other: _____

EMPLOYMENT HISTORY

List most recent employment first. Include summer or temporary jobs. Be sure all your experience or employers related to this job are listed here, in the summary following this section or on an extra sheet of paper if necessary. No more than 10 years history recommended.

Employer name and address:	Position title/duties, skills:	Start date:	End date:
		Reason for leaving:	
Pay: $			
Per:	Supervisor: Telephone:		
Employer name and address:	Position title/duties, skills:	Start date:	End date:
		Reason for leaving:	
Pay: $			
Per:	Supervisor: Telephone:		
Employer name and address:	Position title/duties, skills:	Start date:	End date:
		Reason for leaving:	
Pay: $			
Per:	Supervisor: Telephone:		
Employer name and address:	Position title/duties, skills:	Start date:	End date:
		Reason for leaving:	
Pay: $			
Per:	Supervisor: Telephone:		

ımarize other employment related to this job:

EDUCATION

	Institution name	Years completed	Field of study	Graduate or degree
ı school				
ege/university				
iness/technical				
itional				

MILITARY

you a veteran? ☐ Yes ☐ No

y/specialized training: _____

SKILLS & QUALIFICATIONS

er qualifications such as special skills, abilities or honors that should be considered:

es of computers, software, and other equipment you are qualified to operate or repair:

essional licenses, certifications or registrations:

itional skills, including supervision skills, other languages or information regarding the career/occupation you wish to bring ıe employer's attention:

ing speed: _____ per minute

REFERENCES

two personal references who are not relatives or former supervisors.

ıe	Address	Telephone	Occupation	Years known
e	Address	Telephone	Occupation	Years known

CONTACT

ase of accident or illness, please contact: Name: _____ Daytime phone: _____

ress: _____ Relationship: _____

INFORMATION TO THE APPLICANT

art of our procedure for processing your employment application, your personal and employment references may be checked. If you misrepresented or omitted any facts on this application, and are subsequently hired, you may be discharged from your job. You may e a written request for information derived from the checking of your references.

cessary for employment, you may be required to: supply your birth certificate or other proof of authorization to work in the United es, have a physical examination and/or a drug test, or to sign a conflict of interest agreement and abide by its terms. I understand and e to the information shown above.

ature of Applicant Date

l Employment Opportunity: While many employers are required by federal law to have an Affirmative Action Program, all employers are required to de equal employment opportunity and may ask your national origin, race and sex for planning and reporting purposes only. This information is optional ailure to provide it will have no affect on your application for employment.

loped at employer request by the Alaska Department of Labor & Workforce Development, Employment Security Division.

APPLICATION FOR DISABLED PERSON PLACARD OR PLATES

DMV USE ONLY
SECTION(S) A R/O Comm. (CIRCLE)
NO. VERIFIED BY: (INITIALS & ID #) _____
☐ DCS ATTACHED

NOTE: For lost, stolen, or mutilated Disabled Person or Disabled Veteran License Plates or Placard, please complete Application For Replacement Plates, Stickers, and Documents (REG 156) form, available at ***www.dmv.ca.gov***.

Attention Disabled Veterans with a 100% Disability Rating: You may be eligible for a Disabled Veteran License Plate, which is exempt from the payment of the registration and license fees. Documentation from the Department of Veterans Affairs along with DMV form REG 256A is required – see ***www.dmv.ca.gov*** or call 1-800-777-0133.

A. DISABLED PERSON'S INFORMATION (*PLEASE PRINT*)

TRUE FULL NAME (*LAST, FIRST, MIDDLE OR ORGANIZATION NAME*) | DATE OF BIRTH (*NOT REQUIRED FOR ORGANIZATIONS*) Month Day Year

PHYSICAL ADDRESS (*INCLUDE ST., AVE., RD., CT., ETC.*) | APT./SPACE/STE.# | CITY | STATE | ZIP CODE | DRIVER LICENSE/ID CARD NUMBER

MAILING ADDRESS (*IF DIFFERENT FROM PHYSICAL ABOVE*) APT./SPACE/STE.# | CITY | STATE | ZIP CODE | DAYTIME TELEPHONE NUMBER ( )

Were you ever issued Disabled Person or Disabled Veteran License Plates or a Permanent Parking Placard in California?

☐ **YES** – A doctor's disability certification is **NOT** required, unless the placard was canceled by DMV or is no longer on record.
The Disabled Person or Disabled Veteran License Plates or Placard number is: _____.

☐ **NO** – A doctor's certification is required. The doctor must complete Sections **F** and **G** on the reverse side.

B. PLEASE CHECK AT LEAST ONE OF THE FOLLOWING BOXES:

☐ **Permanent Parking Placard** *No Fee*

☐ **Temporary Parking Placard** *$6.00*
Is this a renewal of a previously issued Temporary Parking Placard? ☐ Yes ☐ No. If Yes, enter the number of consecutively issued placards to you: _____.

☐ **Travel Parking Placard** *No Fee*
Travel Parking Placards are issued to applicants with **permanent** disabilities. A California resident applying for a Travel Parking Placard must have a Permanent Parking Placard or Disabled Person or Disabled Veteran License Plates, but not both. Travel Parking Placards are issued to non-residents for no more than 90 days and to California residents for no more than 30 days.

☐ **Disabled Person License Plates** *No Fee (see Section C)*
NOTE: Disabled Person License Plates can only be assigned to vehicles currently registered in the name of the qualified disabled person.

C. DISABLED PERSON LICENSE PLATE APPLICANTS – *DO NOT COMPLETE IF APPLYING FOR A PARKING PLACARD ONLY.*

Please list the vehicle registered to you on which you will place the Disabled Person License Plates:

CURRENT LICENSE PLATE NUMBER	VEHICLE IDENTIFICATION NUMBER	MAKE

COMMERCIAL VEHICLE EXEMPTION

I am requesting an exemption from weight fees for the vehicle described above. It weighs less than 8,001 pounds unladen. **I understand that this exemption may be used for ONE commercial vehicle only and I do not have this exemption for any other vehicles I own.** ☐ **Yes** ☐ **No**

D. IMPORTANT INFORMATION – *PLEASE READ*

- The only legal use of a placard is its display by the person to whom it is issued. It cannot be loaned to anyone, including family members or friends and a peace officer or parking enforcement person may confiscate a placard being used for parking purposes that benefit a person other than the person to whom the placard was issued. A placard ID card identifying the placard owner is issued with every placard and should be kept with the placard owner at all times whenever the placard is in use, and presented upon request of a peace officer or a person authorized to enforce parking laws, ordinances, or regulations. The disabled person does not have to own or drive the vehicle to use the placard.
- Placard abuse or misuse can result in the **confiscation, cancellation,** and **revocation** of the placard and loss of the privileges it provides.
- Placard and Disabled Person License Plate abuse is a misdemeanor punishable by a fine of not less than $250, not more than $1,000, or by imprisonment in a county jail for not more than 6 months, or by both fine and imprisonment. The court may also impose a civil penalty of not more than $1,500, for each conviction.
- To alter, forge, counterfeit or falsify a plate is a felony punishable by 16 months to 3 years in a state prison or up to 1 year in the county jail.
- A person who forges, counterfeits, falsifies or passes, attempts to pass, acquires, possesses, sells, or attempts to sell a genuine or counterfeit placard, or a person who displays with fraudulent intent, or causes or permits to be displayed a forged, counterfeit or false placard is guilty of a misdemeanor and upon conviction shall be punished by imprisonment in the county jail for 6 months or by a fine of not less than $500 or more than $1,000, or by both fine and imprisonment. The court may also impose a civil penalty of not more than $4,200 for each conviction.
- Any information contained in this application will be available to local public law enforcement or the local agencies responsible for the enforcement of parking regulations. DMV compares its record of disability placards issued against the records of the Bureau of Vital Statistics.
- **The plate and/or placard must be surrendered to DMV within 60 days of the death of the disabled person.**

IT IS ILLEGAL

- To alter a placard or placard identification card.
- To provide false information to obtain a placard or disabled person plates.
- To allow someone to use your placard, if you are not in the vehicle.
- To forge a doctor's signature.
- To possess or display a counterfeit placard.
- For an individual to have more than one permanent placard.

F DISABLED PERSON'S SIGNATURE AND CERTIFICATION – *MUST CHECK BOX AND LIST REASON.*

I have read the "Important Information" in Section D and I fully understand and take responsibility for the use of the Disabled Person Placard or Plates that are issued to me. ***I also certify that I am a disabled person per California Vehicle Code (CVC) §295.5 (as defined in Section F) and that I am:*** ☐ **Permanently** or ☐ **Temporarily** disabled due to: _____

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED AT (*PLACE SIGNED [CITY, STATE]*)	SIGNATURE OF APPLICANT	DATE
	X	

'E: ONLY ORIGINAL SIGNATURES WILL BE ACCEPTED—NO FAXES OR PHOTOCOPIES. ANY ALTERATIONS, CROSSOVERS, OR TEOUT WILL VOID THIS FORM (INCLUDING CHANGES WITH INITIALS) AND WILL BE RETURNED TO THE PATIENT. ORIGINAL FORMS ' MOST CURRENT VERSION IS AVAILABLE AT WWW.DMV.CA.GOV, AND AT ALL DMV OFFICES.

DOCTOR'S CERTIFICATION OF DISABILITY (*PLEASE PRINT LEGIBLY*)

ll legible description of the illness or disability **must be provided** for numbers 3, 4, 5, 6 and 7 below. A licensed physician, surgeon, ician assistant, nurse practitioner, or certified nurse midwife, may certify to items 1–7, a licensed chiropractor may certify to items only, and a licensed physician or surgeon who specializes in diseases of the eye or a licensed optometrist may only certify to item 8.

atient meets the requirements of a disabled person found in California Vehicle Code (CVC) §295.5 as he or she suffers from the following:

DISABLED PERSON'S NAME

] A lung disease to the extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter **or** arterial oxygen tension (pO2) is less than 60 mm/Hg on room air while the person is at rest.

] A cardiovascular disease to the extent that the person's functional limitations are classified in severity as class III or class IV based upon standards accepted by the American Heart Association.

] A diagnosed disease or disorder which substantially impairs or interferes with mobility due to *(please print)*:

_____.

] A severe disability in which he or she is unable to move without the aid of an assistive device, which is due to *(please print)*:

_____.

] A significant limitation in the use of lower extremities due to *(please print)*:

_____.

] The loss, or loss of the use of one or more lower extremities. Loss of use due to *(please print)*:

_____.

] The loss, or loss of the use of, both hands. Loss of use due to *(please print)*:

_____.

] Central visual acuity does not exceed 20/200 in the better eye, with corrective lenses, as measured by the Snellen test, or visual acuity that is greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.

T CHECK THE APPROPRIATE BOX(ES).

'ERMANENT PLACARD CVC §22511.55)	☐ TEMPORARY PLACARD Valid until: Month _____ Day _____ Year _____ (Cannot exceed six months—Cannot be renewed more than six times consecutively [CVC §22511.59(b)].)	☐ TRAVEL PLACARD Valid until: Month _____ Day _____ Year _____ (Cannot exceed 30 days for a California resident and 90 days for a non-resident [CVC §22511.5(d)].)

AUTHORIZED MEDICAL PROVIDER'S SIGNATURE AND CERTIFICATION (*IMPORTANT: ALL INFORMATION BELOW IS REQUIRED. INCOMPLETE FORMS WILL BE RETURNED TO THE PATIENT.*)

AUTHORIZED MEDICAL PROVIDER'S NAME (*LAST, FIRST, MIDDLE*)	AUTHORIZED MEDICAL PROVIDER'S DAYTIME TELEPHONE #
	( )

RIZED MEDICAL PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

ify that I am a ☐ Physician ☐ Surgeon ☐ Chiropractor ☐ Optometrist ☐ Physician Assistant ☐ Nurse Practitioner ertified Nurse Midwife and I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is and correct. I also certify that I will retain information sufficient to substantiate this certification and shall make that information available for ction by the Medical Board of California at the department's request. (CVC §22511.55).

TED AT (CITY, STATE)	DATE

RIZED MEDICAL PROVIDER'S SIGNATURE (*SIGN ONLY AFTER NAME OF PATIENT HAS BEEN PRINTED ABOVE IN SECTION F*)	MEDICAL LICENSE NUMBER

n this form is completed, it may be mailed to: **DMV Placard**
P.O. Box 932345
Sacramento, CA 94232-3450

or submitted to any DMV office. It is recommended that you make an appointment if submitting this form to your nearest DMV office, by calling 1-800-777-0133.

ERTIFICATION OF READILY OBSERVABLE AND UNCONTESTED PERMANENT DISABILITY (*DMV USE ONLY*)

URE OF DMV EMPLOYEE	LINE DATE STAMP

SOCIAL SECURITY ADMINISTRATION ☐ TEL Form Approved OMB No. 0960-0060 TOE 120/145

(Do not write in this space)

APPLICATION FOR DISABILITY INSURANCE BENEFITS

I apply for a period of disability and/or all insurance benefits for which I am eligible under title II and part A of title XVIII of the Social Security Act, as presently amended.

PART I - INFORMATION ABOUT THE DISABLED WORKER

1.	(a) PRINT your name →	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(b) Enter your name at birth if different from item (a) →		
	(c) Check (X) whether you are →	☐ Male	☐ Female
2.	Enter your Social Security Number →	___ ___ ___ / ___ ___ / ___ ___ ___ ___	
3.	(a) Enter your date of birth →	MONTH, DAY, YEAR	
	(b) Enter name of State or foreign country where you were born. →		

If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 4.

	(c) Was a public record of your birth made before you were age 5?	☐ Yes	☐ No	☐ Unknown
	(d) Was a religious record of your birth made before you were age 5?	☐ Yes	☐ No	☐ Unknown
4.	(a) What are the illnesses, injuries, or conditions that limit your ability to work? (Give a brief description.)			
	(b) Are your illnesses, injuries, or conditions related to your work in any way? →	☐ Yes	☐ No	
5.	(a) When did you become unable to work because of your illnesses, injuries or conditions? →	MONTH, DAY, YEAR		
	(b) Are you still unable to work? →	☐ Yes	☐ No	
	(c) If you are no longer unable to work because of your illnesses, injuries or conditions, enter the date you became able to work. →	MONTH, DAY, YEAR		
6.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? →	☐ Yes (If "Yes," answer (b) and (c).)	☐ No (If "No," or "Unknown," go on to item 7.)	☐ Unknown
	(b) Enter name of person on whose Social Security record you filed other application. →			
	(c) Enter Social Security Number of person named in (b). *If unknown, check this block.* ☐ →	___ ___ ___ / ___ ___ / ___ ___ ___ ___		
7.	(a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968? →	☐ Yes (If "Yes," answer (b) and (c).)	☐ No (If "No," go on to item 8.)	
	(b) Enter dates of service →	FROM: (Month, year)	TO: (Month, year)	
	(c) Have you *ever* been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (include Veterans Administration benefits *only* if you waived military retirement pay) →	☐ Yes	☐ No	

(a) Have you filed (or do you intend to file) for any other public disability benefits? (Include workers' compensation and Black Lung benefits) →	☐ Yes (If "Yes," answer (b).)	☐ No (If "No," go on to item 9.)

(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply):

☐ Veterans Administration Benefits ☐ Welfare

☐ Supplemental Security Income ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)

(a) Do you have social security credits (for example, based on work or residence) under another country's Social Security System? (If "Yes," answer (b).) (If "No," go on to item 10.) →	☐ Yes	☐ No
(b) List the country(ies): →		

(a) Are you entitled to, or do you expect to become entitled to, a pension or annuity based on your work after 1956 not covered by Social Security?	☐ Yes (If "Yes," answer (b) and (c).)	☐ No (If "No," go on to item 11.)
(b) ☐ I became entitled, or expect to become entitled, beginning	MONTH	YEAR
(c) ☐ I became eligible, or expect to become eligible, beginning	MONTH	YEAR

agree to notify the Social Security Administration if I become entitled to a pension or annuity based on my employment after 1956 not covered by Social Security, or if such pension of annuity stops.

(a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year?	☐ Yes (If "Yes," skip to item 12.)	☐ No (If "No," answer (b).)
(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.		

Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 14.

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began		Work Ended (If still working show "Not Ended")	
	MONTH	YEAR	MONTH	YEAR
(If you need more space, use "Remarks" space on page 4.)				

May the Social Security Administration or the State agency reviewing your case ask your employers for information needed to process your claim? →	☐ Yes	☐ No

THIS ITEM MUST BE COMPLETED, EVEN IF YOU WERE AN EMPLOYEE.

(a) Were you self-employed this year and last year? (If "Yes," answer (b).) (If "No," go on to item 15.) →	☐ Yes	☐ No

(b) Check the year or years in which you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from your trade or business $400 or more? (Check "Yes" or "No")	
☐ This year			
☐ Last year		☐ Yes	☐ No
☐ Year before last		☐ Yes	☐ No

(a) How much were your total earnings last year? (Count both wages and self-employment income. If none, write "None.") →	Amount $_____
(b) How much have you earned so far this year? (If none, write "None.") →	Amount $_____

	(c) Did you receive any money from an employer(s) on or after the date in item 5(a) when you became unable to work because of your illnesses, injuries, or conditions? (If "Yes", give the amounts and explain in "Remarks" on page 4.) →	☐ Yes ☐ No Amount $_____
	(d) Do you expect to receive any additional money from an employer such as sick pay, vacation pay, other special pay? (If "Yes," please give amounts and explain in "Remarks" on page 4.) →	☐ Yes ☐ No Amount $_____

PART II – INFORMATION ABOUT THE DISABLED WORKER AND SPOUSE

16.	Have you ever been married? → (If "Yes," answer item 17.) (If "No," go on to item 18.)	☐ Yes ☐ No

17. (a) Give the following information about your current marriage. If not currently married, show your last marriage below.

		To whom married	When (Month, day, year)	Where (Name of City and State)
Your current or last marriage	How marriage ended (If still in effect, write "Not Ended.")		When (Month, day, year)	Where (Name of City and State)
	Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)		Spouse's date of birth (or age)	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate)		___ ___ / ___ ___ /___ ___ ___ ___	

(b) Give the following information about each of your previous marriages. (If none, write "NONE.")

		To whom married	When (Month, day, year)	Where (Name of City and State)
Your previous marriage	How marriage ended		When (Month, day, year)	Where (Name of City and State)
	Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)		Spouse's date of birth (or age)	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate)		___ ___ ___ / ___ ___ /___ ___ ___ ___	

(Use a separate statement for information about any other marriages.)

18.	Have you or your spouse worked in the railroad industry for 7 years or more? →	☐ Yes ☐ No

PART III – INFORMATION ABOUT THE DEPENDENTS OF THE DISABLED WORKER

19. If your claim for disability benefits is approved, your children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.

List below: FULL NAME OF ALL such children who are now or were in the past 12 months UNMARRIED and:
- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

(IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 20.)

20.	Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? (If "Yes," enter name and address in "Remarks" on page 4.)	☐ Yes ☐ No

IMPORTANT INFORMATION ABOUT DISABILITY INSURANCE BENEFITS — PLEASE READ CAREFULLY

I. SUBMITTING MEDICAL EVIDENCE: I understand that as a claimant for disability benefits, I am responsible for providing medical evidence showing the nature and extent of my disability. I may be asked either to submit the evidence myself or to assist the Social Security Administration in obtaining the evidence. If such evidence is not sufficient to arrive at a determination, I may be requested by the State Disability Determination Service to have an independent examination at the expense of the Social Security Administration.

II. RELEASE OF INFORMATION: I authorize any physician, hospital, agency or other organization to disclose to the Social Security Administration, or to the State Agency that may review my claim or continuing disability, any medical record or other information about my disability.
I also authorize the Social Security Administration to release medical information from my records, only as necessary to process my claim, as follows:

- Copies of medical information may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any evidence necessary for determining my eligibility for rehabilitative services.

THIS MUST BE ANSWERED → 21. DO YOU UNDERSTAND AND AGREE WITH THE AUTHORIZATIONS GIVEN ABOVE? ☐ Yes ☐ No (If "No," explain why in "Remarks.")

Check if applicable:

☐ I am not submitting evidence of ☐ my ☐ the deceased's earnings that are not yet on ☐ my ☐ his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in benefits will be paid with full retroactivity.

MARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

III. REPORTING RESPONSIBILITIES: I agree to promptly notify Social Security if:

- My MEDICAL CONDITION IMPROVES so that I would be able to work, even though I have not yet returned to work.
- I GO TO WORK whether as an employee or a self-employed person.
- I apply for or begin to receive a workers' compensation (including black lung benefits) or another public disability benefit, or the amount that I am receiving changes or stops, or I receive a lump-sum settlement.
- I am confined to jail, prison, a penal institution or correctional facility for conviction or a crime or I am confined to a public institution by court order in connection with a crime.

The above events may affect my eligibility or disability benefits as provided in the Social Security Act, as amended.

ow that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in rmining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I n that all information I have given in this document is true.

SIGNATURE OF APPLICANT	Date (Month, day, year)
ature (First name, middle initial, last name) (Write in ink) N → E	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

R FICIAL E ONLY	Direct Deposit Payment Address *(Financial Institution)*			
	Routing Transit Number	C/S	Depositor Account Number	☐ No Account ☐ Direct Deposit Refused

licant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)*

and State	ZIP Code	County *(if any)* in which you now live

nesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the ing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

Signature of Witness	2. Signature of Witness
lress *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State and ZIP Code)*

FOR YOUR INFORMATION

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

Collection and Use of Information From Your Application — Privacy Act Notice/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(b), 402(c), 405(a), and 1395(ii). While it is VOLUNTARY, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage.

Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows: 1. to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT NOTICE AND TIME IT TAKES STATEMENT:

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

SON TO CONTACT ABOUT YOUR CLAIM	SSA OFFICE	DATE CLAIM RECEIVED
EPHONE NUMBER (INCLUDE AREA CODE)		

r application for Social Security disability benefits has n received and will be processed as quickly as possible.

I should hear from us within _____ days after you have en us all the information we requested. Some claims may e longer if additional information is needed.

he meantime, if you change your address, or if there is some other change that may affect your claim, you — or someone for you — should report the change. The changes to be reported are listed below.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID

- You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Custody Change—Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.

- Change of Marital Status—Marriage, divorce, annulment of marriage.
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- If you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stops, or you receive a lump-sum settlement.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above changes occur, the change(s) should be reported by calling:

_____

(Telephone Number—Include Area Code)