EDUCATIONAL OPPORTUNITY PROGRAM (EOP)
NON-TAXABLE INCOME VERIFICATION FORM

THIS FORM IS ONLY FOR APPLICANTS WHOSE FAMILIES RECEIVE FUNDING (SUCH AS PUBLIC ASSISTANCE/SOCIAL SERVICE, SOCIAL SECURITY, SSI, ETC.). THE AGENCY WHO COORDINATES YOUR BENEFITS MAY SUBMIT A SIGNED AND STAMPED LETTER IN SUBSTITUTION OF THIS FORM. THE LETTER MUST INCLUDE THE INFORMATION REQUESTED BELOW.

The applicant listed below is applying for admission to the Educational Opportunity Program (EOP) at SUNY Plattsburgh. To determine the applicant's economic eligibility, we must obtain proof of non-taxable benefits. Please help the applicant to complete their application to EOP by providing the required information on the lines below OR by providing a signed/stamped statement of annual benefits on agency letterhead.

TO BE COMPLETED BY THE APPLICANT TO SUNY PLATTSBURGH

Applicant’s Name__________________________________________________________________________
Name of the Recipient of the Benefit Being Reported Here (if different from applicant)
_________________________________________________________________________________________
Relationship to Applicant___________________________________________________________________
Case Number_____________________________________________________________________________

TO BE COMPLETED BY THE VERIFYING AGENCY

An Official Agency Seal or Stamp* is required to complete this form.

TOTAL BENEFITS paid to the benefit/income recipient during the 2018 year = $__________________

Period of coverage: From____________/____________ To____________/____________

Family members covered:

Name Relationship to Benefit/Income Recipient
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Agency Name* (Please Print) Type of Benefits
___________________________________________
Agency Official (Please Print) Title
___________________________________________
Signature Telephone Number

*PLEASE AFFIX AGENCY STAMP OR SEAL BELOW TO VERIFY ALL INFORMATION.

Return completed forms to the applicant to be forwarded to the Financial Aid Office at SUNY Plattsburgh.