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Student Financial Aid Office

THIS FORM IS TO BE COMPLETED BY THE DEPARTMENT OF SOCIAL SERVICES (WELFARE). THIS INFORMATION IS NECESSARY IN ORDER TO DETERMINE YOUR ELIGIBILITY FOR THE SEEK PROGRAM.

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**This sections needs to be completed by Student/Family:**

Student's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Payee: \_\_\_\_\_ Case No.: \_\_\_\_\_

Payment Category: \_\_\_\_\_

We made our first payment to this family in (Month) \_\_\_\_\_ (Year) \_\_\_\_\_

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**This sections needs to be completed by Department of Social Services:**

Funding was provided for this family during 2015.

Total benefits paid in 2015 was \$ \_\_\_\_\_. Benefits were provided for the following family members:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

\_\_\_\_\_  
Signature of Agency Representative

\_\_\_\_\_  
Agency Seal or Stamp\*

\*If the agency has no official seal or stamp, please attach a statement on agency stationary that verifies the validity of the completed form.

**AFTER COMPLETED BY BOTH PARTIES RETURN TO: SEEK Financial Aid Counselor**  
at the College of Staten Island address listed above.