



High School Equivalency Program (HEP) University of Texas at El Paso

Student Application
(English)

J GR'F 'P wo dgt< _____ UTEP ID Number: _____

I. Personal Information

Name: _____ Texas ID/DL Number: _____
Last First Middle Name

Date of birth: ____/____/____ Age: _____ Gender: Male Female
Month Day Year

Permanent Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Tel. Number: (____) _____ - _____ Cell Number: (____) _____ - _____ Email: _____

Birth Place: _____ Marital Status: Married Single Divorced Other

Emergency Contact name: _____ Relationship: _____ Tel. Number: (____) _____ - _____

US Citizen: Yes No US Resident: Yes No Other:

Ethnic Background: White, Non-Hispanic Asian/Pacific Islander
 Black, non-Hispanic American Indian/Alaskan Native
 Hispanic

Occupation of Head of Household: _____

List every person living at home, include yourself:

Name	Age	Relationship	Present Occupation
_____	_____	Self	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

With a few exceptions, you are entitled on your request to be informed about the information the University of Texas at El Paso collects about you. Under Sections 552.021 and 552.023 of Texas Government code, you are entitled to receive and review the information. Under Section 559.004 of Texas Government Code, you are entitled to have the University of Texas at El Paso correct information about you that is held by us and that is incorrect, in accordance to the procedures set forth in the University of Texas System Business Procedures Memorandum 32. The information that the University of Texas at El Paso collects will be retained and maintained as required by Texas records retention laws(Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different period of time.

FOR OFFICE USE ONLY

DO NOT WRITE BELOW THIS LINE

_____ English _____ Spanish _____ Dorm _____ Commuter _____ Homebound / Remote

II. Academic Information

U.S. Schools
School name, City & State
Elementary
Middle School
High School

Other Countries
School name, City & State
Elementary
Middle School
High School
University

Last Grade Completed: _____

Date of withdrawal: _____ / _____

What is the primary language spoken at home? _____

How did you find out about HEP? _____

Why did you Leave school? _____

III. Farm work information(SECTION III IS TO BE FILLED BY HEP STAFF).....

REQUIREMENTS FOR ELIGIBILITY AND CERTIFICATION

The applicants must be 17 years of age and over, or beyond the age of compulsory school attendance in the State in which such persons reside and are not enrolled in school

And

Who themselves, or whose immediate family, have spent a minimum of 75 days during the past 24 month in migrant and seasonal farm work

And/or

Who are eligible to participate, or have participated within the preceding 2 years, in programs under part C of title I of the Elementary and Secondary Education Act of 1965, or section 167 of the Workforce Investment Act of 1998

And

Who lack a high school diploma or its equivalent.

Applicant qualifies under the following criteria

1. Seasonal/Temporary Farm Work 2. Migrant Program-COE 3. W.I.O.A. Section 167 (MET-El Paso, TX)

1. Seasonal/Temporary Farm Work

❖ A person who themselves, or whose immediate family, have spent a minimum of 75 days, during the past 24 months in migrant and seasonal farm work.

Documentation:

Check stubs W-2 Form /Tax return Income Verification form Letter from employer Employment Eligibility Verification

Employer's Name: _____

Person working: _____

Address: _____

Dates of Employment: Start: _____ / _____ End: _____ / _____
Month Year Month Year

Phone: (____) _____ - _____

Earnings: Start: _____ End: _____

Type of Work Performed: _____

Contact Person/Title: _____

Contact Method: Phone Mail Person Documentation

Employer's Name: _____

Person working: _____

Address: _____

Dates of Employment: Start: _____ / _____ End: _____ / _____
Month Year Month Year

Phone: (____) _____ - _____

Earnings: Start: _____ End: _____

Type of Work Performed: _____

Contact Person/Title: _____

Contact Method: Phone Mail Person Documentation

2. Migrant Program(COE)

❖ The Person must have participated (within the last 24 months), or be eligible to participate, in program under 34 CFR part 201 (Chapter I-Migrant Education Program).

Qualifying Arrival Date: ____/____/____

Expiration Date: ____/____/____

Qualifying Work: Seasonal: Yes No

Temporary: Yes No

Dates: ____/____/____
Start

____/____/____
End

____/____/____
Start

____/____/____
End

Describe Work: _____

3. W.I.O.A. Section 167 (MET-El Paso, Texas)

❖ The person must have participated (within the last 24 months), or be eligible to participate, in the program under CFR part 633 (Employment & Training Administration, department of Labor-Migrant and Seasonal Farmworker Programs-WIOA 167 NFJP).

Date of intake/enrollment begins: ____/____/____
Month Year

Date of intake/enrollment ends: ____/____/____
Month Year

Qualifying Work: Seasonal: Yes No

Temporary: Yes No

Date: ____/____/____
Month Year
Start

____/____/____
Month Year
Ends

Date: ____/____/____
Month Year
Start

____/____/____
Month Year
Ends

Describe Work: _____

IV. Financial Need Information

In the past two years did you, your parents, your spouse or anyone in your household receive benefits from any of the federal benefits programs listed? Mark all that apply.

- Social Security Benefits (SSI) Supplemental Nutrition Assistance Program (SNAP) Free or Reduced Price School Lunch
- Temporary assistance for Needy Families (TANF) Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Medicare / Medicaid

NOTES: _____

I understand that information submitted herein will be relied upon by Program Officials to determine my status for admission and eligibility. I authorize the Program to verify the information I provided. I agree to notify the proper official of the Program of any changes in the information provided. I certify that the information on this application is complete, correct and understand that the submission of false information is grounds for rejection of my application, withdrawal of any offer of acceptance, cancellation of enrollment, or appropriate disciplinary action.

Applicant Signature

Date

Parent or Legal Guardian
(if the participant is under 18 year of age)

V. Vocational Information

Have you ever taken any official GED exams? Yes No

If so, when and where? _____ DATE: _____ / _____ / _____
Month Day Year

Reason(s) for testing (mark ALL that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Enroll in Technical or Trade Program | <input type="checkbox"/> Get First Job | <input type="checkbox"/> Court Order |
| <input type="checkbox"/> Enter a 2-Year College | <input type="checkbox"/> Keep Current Job | <input type="checkbox"/> Public Assistance Requirement |
| <input type="checkbox"/> Enter 4-Year College/University | <input type="checkbox"/> Get a Better Job | <input type="checkbox"/> Role Model for Family |
| <input type="checkbox"/> Skills Certification | <input type="checkbox"/> Employer Requirement | <input type="checkbox"/> Personal Satisfaction |
| <input type="checkbox"/> Job Training | <input type="checkbox"/> Military Entrance | <input type="checkbox"/> Early Release |

Career interest: 1. _____ 2. _____ 3. _____

Your Current Employment Status (Mark ALL that apply)

- | | |
|--|---|
| <input type="checkbox"/> Employed Full-time | <input type="checkbox"/> Not in the Labor Force (homemaker, family caregiver) |
| <input type="checkbox"/> Employed Part-time (20 or fewer hours per week) | <input type="checkbox"/> Not in the Labor Force (unemployed by choice) |
| <input type="checkbox"/> Unemployed (seeking employment) | <input type="checkbox"/> Permanent Disability |
| | <input type="checkbox"/> Retired |

VI. Medical Information

Medical Information is strictly for the use of Health Services and will not be released without your consent. You are not require to see a physician before coming to the program.

Student's name: _____
Last First Middle

Family Doctor's Name: _____ Family Doctor's Telephone Number: (_____) _____ - _____

Family Doctor's Address: _____
Street City State Zip

Is the student covered by medical insurance? Yes No If yes, what kind? Medicaid Parent's Other
Employer Insurance

Medical Insurance Company: _____

Policy Number: _____

Please identify any special medication, allergies or other medical condition(s) which may affect decisions concerning medical treatment of the participant in any emergency situation.

Should there be any limits on his/her physical activity? If so, what are they and why?

Has the participant had any serious illness in the last three years? If so, explain

