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

Student Application
(English)

**HEP ID Number: _____** **UTEP ID Number: _____**

## I. Personal Information

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

**Date of birth:**_____/_____/____ **Social Security #:**_____-_____-_____ **Age:**_____ **Gender:** ☐**Male** ☐**Female**
Month Day Year (Used solely for record-keeping & internal institutional purposes)

**Permanent Address:**_____
Street City State Zip

**Mailing Address:**_____
Street City State Zip

**Telephone 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** **US Resident Number:**_____

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

**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**

## II. Academic Information

**Last School Attended:**_____ **City:**_____ **State:**_____

**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 ELIGIILITY 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 Farm Work** **2.** ☐ **Migrant Program-COE** **3.** ☐ **W.I.O.A. Section 167 (MET-El Paso, TX)**

### 1. ☐ Seasonal 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

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**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:**_____/_____ **Date of intake/enrollment ends:**_____/_____
Month Year Month Year

**Qualifying Work:** **Seasonal:** Yes ☐ No ☐ **Temporary:** Yes ☐ No ☐

**Date:**_____/_____ _____/_____ **Date:**_____/_____ _____/_____
Month Year Month Year Month Year Month Year
Start Ends Start 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.**

☐ Supplemental Security Income ☐ Food Stamps ☐ Free or Reduced Price School Lunch

☐ Temporary assistance for Needy Families (TANF) ☐ Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

**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** **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)**

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

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

**Your Current Employment Status (Mark ALL that apply)**

☐ Employed Full-time
☐ Employed Part-time (20 or fewer hours per week)
☐ Unemployed (seeking employment)
☐ Not in the Labor Force (homemaker, family caregiver)
☐ Not in the Labor Force (unemployed by choice)
☐ Permanent Disability
☐ 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 Employer Insurance ☐ Other

**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