Washington State Department of CHILDREN, YOUTH & FAMILIES

Extended Guardianship Assistance Program (EGAP) Application

General Directions

Youth who were placed into guardianship from foster care and have received a GAP subsidy might qualify for EGAP benefits.

- Complete this form when applying for EGAP along with the EGAP application DCYF 07-017
- Both the guardian and youth need to fill out this application to apply for the EGAP program.
- Submission: Submit the completed form to your HQ GAP Specialist or email: dcyf.gapspecialist@dcyf.wa.gov

SECTION 1 – Applicant Information

Child or Youth

Name of Youth (*First, Last, Middle*)

Date of Birth Date of Request

Case ID

Street Address

City State Zip

Telephone Email

Prospective Guardians

Complete each section for each guardian.

Guardian 1

Name of Guardian (*First, Last, Mi)*

Date of Birth

Relationship to Youth (example – uncle, grandparent)

Street Address

City State Zip

Telephone Email

Guardian's primary language if not English

Do you need an interpreter? ☐ Yes ☐ NO

Guardian 2 *If there is only 1 guardian*, *check* ☐ NA

Name of Guardian (*First, Last, Mi)*

Date of Birth

Relationship to Youth (example – uncle, grandparent)

Street Address

City _____ State _____ Zip _____

Telephone _____ Email _____

Guardian's primary language if not English _____

Do you need an interpreter? ☐ Yes ☐ No

SECTION 2 – EGAP Eligibility Activities

Choose the activity the youth is currently enrolled in. Remember that you'll need to provide documentation of participation in the activity selected.

☐ 1. High School

(a) Name of Program_____

(b) Anticipated Date of Graduation _____

☐ 2. College or vocational program

(a) Name of school _____

(b) Area of Study Area of Study _____

(c) Anticipated Completion Date: _____

☐ 3.Job Training Program or Activity

(a) Name of Program _____

(b) Anticipated Completion Date:_____

☐ 4. Working over 80 hours a month. Employer's Name _____

☐ 5. Medical Condition that prevents participation in any of the above.

Describe: *Extra space is proved on the last page of this form if needed*

Additional eligibility questions.

1. Will the youth enroll in a different program after finishing the current one? ☐ No ☐ Yes
   If yes, what type of program and where:
2. Does the youth receive any social security benefits? ☐ No ☐ Yes; if yes, what type and how much?
   _____
3. Is the youth married? ☐ No ☐ Yes
4. Is the youth in the military or will be going into the military in the next 6 months? ☐ No ☐ Yes
5. Will youth be applying for food stamps or welfare benefits? ☐ No ☐ Yes

SECTION 3 – Youth Acknowledgement

Put an X on the box showing you have read and agree to each statement.

I understand to qualify for EGAP benefits, I must:

- ☐ 1. Be involved in one of these activities:
  - (a) Stay enrolled in high school or similar program,
  - (b) Attend college or vocational program,
  - (c) Be in a job training program,
  - (d) Work more than 80 hours per month, or
  - (e) Have a documented medical condition that stops me from doing the above activities.
- ☐ 2. Get financial support from my guardians.
- ☐ 3. Live with my guardian or in a supervised independent living arrangement approved by DCYF and my guardian.
- ☐ 4. Provide proof to the DCYF HQ GAP Specialist of the required EGAP activity every 6 months.
- ☐ 5. Report any changes in my status to the guardianship assistance program within 30 days.
- ☐ 6. Send changes and proof of participation to the HQ Guardianship Unit via email: dcyf.guardianshipspecialists@dcyf.wa.gov

I have checked this application and confirm that the information and documents I provided are accurate to the best of my knowledge. I understand that giving false information could lead to my application being rejected.

Youth's Signature _____ **Date** _____

SECTION 4– Guardian Acknowledgement

Put an X on the box showing you have read and agree to each statement.

To qualify for EGAP benefits for my youth, I must:

- ☐ 1. Ensure my youth is involved in one of these activities:
  - (a) Enrolled in high school or similar program,
  - (b) Attends college or vocational program,
  - (c) Goes to a training program,
  - (d) Works more than 80 hours per month, or
  - (e) Has a documented medical condition that stops me from doing the above activities.
- ☐ 2. Provide financial support for the youth.
- ☐ 3. Provide ongoing proof to the DCYF HQ GAP Specialist the youth is participating in one of the required EGAP activities every 6 months.
- ☐ 4. Report any changes in my status to the guardianship assistance program within 30 days.
- ☐ 5. Send changes and proof of participation to the HQ Guardianship Unit via email: dcyf.guardianshipspecialists@dcyf.wa.gov

I have checked this application and confirm that the information and documents I provided are accurate to the best of my knowledge. I understand that giving false information could lead to my application being rejected.

Guardian 1 Signature _____ **Date** _____

Guardian 2 Signature _____ **Date** _____

Extra Space if Needed