

2009-10 DEPENDENT CARE SUPPLEMENT REQUEST FORM

Students who have dependents other than a spouse (such as younger children or elderly dependent parents) for whom they have financial responsibility are eligible to apply for supplemental loan assistance to help offset the costs for dependent care. Allowable costs include day care expenses, child care services, etc. Increases are not permitted for the costs of food and shelter for dependents. These costs are factored into the standard income protection allowance used when determining the expected family contribution toward educational expenses. The amount of supplement is based on actual costs incurred within limits for what is considered fair and reasonable rates (**maximum of \$750/month per eligible dependent**).

Please complete information below if you wish to apply for a dependent care supplement. Return the completed form along with second-party documentation of your actual dependent care costs to our office. Documentation should include (but not be limited to) a minimum of one billing statement from each service provider along with a projection of total costs for your academic year. A letter from the service provider can be submitted in lieu of a billing statement provided that it is on letterhead of the service provider and includes their address and telephone number. Remember to have each service provider sign and date the certification section provided below. **Supplement requests for 2009-10 typically will not be accepted after March 31, 2010**

STUDENT NAME: _____

(Please Print)

SOCIAL SECURITY # : _____ DEGREE PROGRAM: _____

GRADUATION DATE: _____ MARITAL STATUS: _____

CURRENT LOCAL ADDRESS: _____

CURRENT TELEPHONE NUMBER: (____) _____

DEPENDENT(S) RECEIVING CARE:

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

SERVICE PROVIDER #1: (Information about additional service providers should be reported on the reverse side.)

Provider Name: _____

Provider Address: _____

Weekly charge of service: \$ _____ (Attach copy of billing statement as documentation.)

Date(s) of Expense (i.e., time period when service is/will be used): FROM _____ TO _____

Total Estimated Dependent Care expenses for the academic year: \$ _____

Provider Certification: I will provide/have provided dependent care services for the above named individual(s). I certify that the information reported above is correct.

Provider Signature: _____ Date: _____

Student must attach at least one billing statement/invoice from this provider.

STUDENT CERTIFICATION: I certify that the information stated in this request is true and that I will notify your office immediately if there are any changes in my dependent care situation during the 2009 -10 academic year.

Student Signature: _____ Date: _____

Information about additional service providers can be reported below.

SERVICE PROVIDER #2:

Provider Name: _____
Provider Address: _____
Weekly Charge of Service: \$ _____ (Attach copy of billing statement as documentation.)
Date(s) of Expense (i.e., time period when service is/will be used): FROM _____ TO _____
Total Estimated Dependent Care expenses for academic year: \$ _____

Provider Certification: I will provide/have provided dependent care services for the above named individual(s). I certify that the information reported above is correct.

Provider Signature: _____ Date: _____

Student must attach at least one billing statement/invoice from this provider.

SERVICE PROVIDER #3:

Provider Name: _____
Provider Address: _____
Weekly Charge of Service: \$ _____ (Attach copy of billing statement as documentation.)
Date(s) of Expense (i.e., time period when service is/will be used): FROM _____ TO _____
Total Estimated Dependent Care expenses for academic year: \$ _____

Provider Certification: I will provide/have provided dependent care services for the above named individual(s). I certify that the information reported above is correct.

Provider Signature: _____ Date: _____

Student must attach at least one billing statement/invoice from this provider.

**Please attach any additional comments on a separate sheet of paper.
Be sure to include your name, social security number, and program of enrollment.**

Office of Financial Aid Use Only

Eligible Dependents: _____ **Approved** Yes No
Total Allowable Expenses: _____
Maximum Increase: _____ **(\$750/dependent)**
Additional Loan Amount: _____

Loan information: _____

| | Fund name | Item Type | Original Amt | New Amt |
|---------------------|-----------|-----------|--------------|---------|
| Message Codes (PS): | 111 | 599 998 | 999 | |