NORTHWESTERN UNIVERSITY **OFFICE OF FINANCIAL AID**

710 N. Lake Shore Drive (C315) Chicago, IL 60611-3078 *(312) 503-8722*

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 2008-09 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