Northwestern

CHICAGO OFFICE OF FINANCIAL AID

Dependent Care Supplement Request Form

2017-18 Academic Year

Students who have dependents other than a spouse 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 as part of the Dependent Care Supplement since these costs are factored into the standard income protection allowance used when determining the expected family contribution (EFC). The amount of the supplement is based on actual costs incurred within limits for what is considered fair and reasonable rates, and may be prorated based on the student's appeal and financial aid application materials.

Please complete the information below if you wish to apply for a Dependent Care Supplement and return the completed and signed form along with second-party documentation of your actual dependent care costs to our office. Documentation should include (but is not limited to) a minimum of one billing statement from each service provider along with a projection of total costs for the 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 their certification section.

Please attach any additional comments on a separate sheet of paper, and be sure to include your name, student ID number, and program. Supplement requests for the 2017-18 academic year typically will not be accepted after March 31, 2018.

STUDENT NAME: ____
(Please Print)

STUDENT ID #: ______________________ DEGREE PROGRAM: ______________

GRADUATION DATE: ______________________ MARITAL STATUS: ______________

CURRENT LOCAL ADDRESS: ____

____

CURRENT TELEPHONE NUMBER: (_______) ______________________

DEPENDENT(S) RECEIVING CARE:

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: $ ___________

<u>Provider Certification</u>: 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 2017-18 academic year.

____ ______________________

Student Signature (electronic signatures not accepted) *Date Signed*

710 N. Lake Shore Drive, Suite 629, Chicago, IL 60611 | P: (312) 503-8722 | F: (312) 503-8700 | financial-aid-chicago@northwestern.edu

If needed, information about additional dependent care service providers for the 2017-18 academic year can be reported below.

This page does not need to be returned if service providers are not included on this page.

STUDENT NAME: ____ STUDENT ID #: __________________________

SERVICE PROVIDER #2: (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.

SERVICE PROVIDER #3: (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.