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UNT HEALTH SCIENCE CENTER

Financial Aid Child Care Allowance 2018-2019

Name:_____ Student ID#: _____

You are requesting an adjustment to your cost of education. The actual cost for child care will be added to the basic cost of education only if the child care is fully documented. If your children are of age to attend public school, private school education will not be considered. If you are requesting child care funds outside of normal business hours, please provide a written statement of explanation.

Please have your child care provider complete ALL of the information below.

Child's Full Name	Age	Cost per Month	# of Months in child care between July 1, 2018 and June 30, 2019

Children should be 12 years of age or under unless there is an extenuating circumstance.

Child Care Provider Name: _____

Address**:** _____

Phone Number:_____

Name of individual paying for the child care of the above listed child(ren):

_____

_____ _____ _____

Child Care Provider Printed Name Child Care Provider Signature Date

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STUDENT CERTIFICATION:

All of the information provided is true and complete to the best of my knowledge. If requested by an authorized official, I agree to provide additional documentation necessary to verify my request. I certify that I have read and understand the requirements above. **I certify that I am the person paying for the child care.**

Student's signature_____ Date _____