
Student Name
W _____
Student Number

If you will pay out-of-pocket child or dependent care expenses *for dependents residing with you* during the 2009-2010 academic year for care incurred as a result of attending classes at Western (i.e. during periods that include but are not limited to class time, study time, fieldwork, internships, and commuting time to and from the University), please complete all of the information requested below which applies to you. We may be able to increase your aid eligibility for such expenses. Do not include amounts for children over the age of 11.

- 1. Dependent Care Expenses:** Listed below are names, ages, monthly dependent care costs and quarters dependent care is needed for all dependents covered by this request.

<u>Name of Dep.</u>	<u>Age of Dep.</u>	<u>Cost per Month</u>	<u>Qtrs DepCare Needed</u>		
_____	_____	_____	Fall []	Wtr []	Spr []
_____	_____	_____	Fall []	Wtr []	Spr []
_____	_____	_____	Fall []	Wtr []	Spr []
_____	_____	_____	Fall []	Wtr []	Spr []

- 2. Dependent Care Provider Certification:**

I certify that I have contracted with the above-named student to provide dependent care as indicated above.

Dependent Care Provider _____
 (Printed Name)

(Name of Company, if applicable) _____
 (Phone Number)

Dependent Care Provider Address _____

Dependent Care Provider Signature _____
 (Date)

(As an alternative, you may attach a copy of your contract agreement with your dependent care provider, signed by you and your care provider and specifying your monthly payment obligation and the period covered by the Agreement.)

3. **Dependent care expenses that will be paid or reimbursed by someone other than your spouse (if married) on your behalf.** List below the sources and amounts of dependent care support you may receive for those listed in #1 above.

<u>Name of Funding Source.</u>	<u>Amount per Week</u>	<u>Number of Weeks</u>	<u>Qtrs of Funding</u>
_____	_____	_____	Fall [] Wtr [] Spr []
_____	_____	_____	Fall [] Wtr [] Spr []
_____	_____	_____	Fall [] Wtr [] Spr []
_____	_____	_____	Fall [] Wtr [] Spr []

4. **My marital status is (check one)**

- Not married
- Married. If married, complete the following:

a. Spouse's full name (first, last name, middle initial): _____

b. My spouse is attending college ___full time, ___three-quarter time, ___half-time, ___ less than half-time at _____
(name college or university)

c. My spouse works full time: ___Yes ___No (if no, please indicate why your spouse is unable to provide the dependent care) _____

5. **Authorization for loan funding**

Approved cost of attendance increases will be met with gift aid based on student eligibility and the availability of funds. In certain circumstances, loans may need to be added to assist with funding your dependent care costs. You may provide your authorization to increase Federal Direct Loan below:

- Please add or increase my Federal Direct *Subsidized* Loan to my maximum eligibility
- Please add or increase my Federal Direct *Unsubsidized* Loan to my maximum eligibility
- Please add or increase both loans to my maximum eligibility

5. **Student Certification**

I certify that the information provided above is correct, and;
I will inform the Financial Aid Department of any changes in dependent care providers or in dependent care resources and;
I understand that I may request my cost of attendance for dependent care be revised if my costs increase by \$100 or more per quarter.

Student Signature _____ Date _____