KU MEDICAL CENTER
The University of Kansas

Dependent Care Budget Adjustment Request Form 2008-09

Return to:
University of Kansas Medical Center
Student Financial Aid
3901 Rainbow Blvd. 3007 Student Center
Mail Stop 4005
Kansas City, KS 66160-7192
(913) 588-5170 Phone (913) 588-8841 Fax

Office Use Only/Date Stamp

The purpose of this document is to notify the Office of Student Financial Aid of additional expenses that you, the student, are incurring for the reason listed below. An offer of additional aid is not guaranteed. Each adjustment is reviewed on a case-by-case basis. You will be notified in writing (e-mail) of the outcome of your request. Dependent Care Adjustment forms will be accepted until May 1, 2009. Please refer to the Budget Adjustments Policy for more information about budget adjustments for dependent care. www.kumc.edu/studentcenter/financialaid.html

Name_____ KU ID_____
Last First MI

Dependent Care

In order for the Office of Student Financial Aid to determine eligibility for a budget increase for a child care allowance, the following information must be completed by the student (Part 1) and the student's dependent care provider (Part 2). Signatures are required.

Part I: To be completed by Student

Student Marital Status: _____ Married _____ Single _____ Other
Complete the following if married or if both parents/guardians reside in same household:
Spouse/other parent/guardian name: _____
Is spouse/other parent/guardian employed? _____ Yes _____ No
(If spouse is not employed, do not complete Part II)

Dependent care is needed for the following semesters during which I will be enrolled (mark all that apply):
____ Summer 2008 _____Fall 2008 _____ Spring 2009

Dependent Information

Name of Dependent	Age	Relationship

Continued on next page…

Part II: To be completed by care provider

Name of Child Care Facility or Provider**:** _____

License # of Provider if applicable: _____

Phone # of Provider: _____

Child Care Costs:

Name of Child	Weekly Cost*

* Remember to account for any discounts for additional children. Please leave blank if you do not pay for childcare.

Signature of Provider:

_____ _____
PROVIDER'S SIGNATURE **DATE**

Signature of Student:
I attest to the accuracy of the information in this document.

_____ _____
STUDENT'S SIGNATURE **DATE**

For Department Use Only:

Budget Maint. _____
Award Entry _____
Comment _____
Email _____

Date completed _____
By _____