

The Student Financial Aid Office is able to consider requests for additional assistance to cover the cost of dependent care expenses while a student in school. Additional aid is not guaranteed, and 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 should be submitted no later than 45 days prior to the last day of your enrollment for the academic year to allow for processing time. Please refer to the [Cost of Attendance Adjustments Policy](#) for more information about Cost of Attendance (COA) adjustments for dependent care.

To protect your information, it is recommended that all documentation be sent confidentially using your KUMC.EDU email address. Instructions for sending secure emails can be found at the following website:

<https://kumed.sharepoint.com/sites/mykumc/ir/Pages/Secure-Email.aspx>

**STUDENT NAME**

**7-DIGIT STUDENT ID**

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

Maximum Increase:

Birth – 1 year of age	\$297/week
1 year – 3 years of age	\$242/week
3 years – Kindergarten	\$216/week
Kindergarten – 12 years of age	\$126/week (school year)
	\$166/week (summer)

**PART I: TO BE COMPLETED BY THE STUDENT**

Please indicate all individuals whose income was reported on the FAFSA:

- Student     Spouse     Other \_\_\_\_\_

If you checked Spouse or Other, what is the employment status of that individual from June 1, 2022 and May 31, 2023?

- Not working     Full Time     Part Time/Hours per Week \_\_\_\_\_

If you checked Spouse or Other, will that individual be attending school any time between June 1, 2022 and May 31, 2023?

- Yes     No

If yes, what school? \_\_\_\_\_

*If enrolled at a school other than the University of Kansas Medical Center, please provide a statement from that school indicating the amount of financial assistance being provided from them for dependent care.*

Dependent care is needed for the following semesters during which I will be enrolled (mark all that apply):

- Summer 2022                  Fall 2022                  Spring 2023

**Dependent Information**

Name of Dependent	Current Age	Relationship

**Office of Student Financial Aid**

**PART II: TO BE COMPLETED BY CARE PROVIDER**

Name of Child Care Facility or Provider: \_\_\_\_\_

Child Care License # of Provider: \_\_\_\_\_ Phone # of Provider: \_\_\_\_\_

**Childcare Costs:**

Name of Dependent	Weekly Cost*

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

**I attest to the accuracy of the information provided.**

\_\_\_\_\_  
**PROVIDER SIGNATURE**

\_\_\_\_\_  
**DATE**

**Please attach proof of payment for at least one month's worth of care for each dependent. This can be in the form of a canceled check (front and back of check must be provided), cashier's check/money order, credit card receipt, bank statement, etc.**

To protect your information, we ask that all documentation be sent confidentially using your KUMC.EDU email address. To send a secure email, place a [secure] at the beginning of the subject line in your email. More information can be found at this site:

<https://kumed.sharepoint.com/sites/mykumc/ir/Pages/Secure-Email.aspx>

**Please check the boxes below, indicating that you have read and agree to the following:**

I have submitted all required documentation, and understand that the Student Financial Aid Office will revise my award, if appropriate, after the appeal has been processed.

I understand that submission of the document does not guarantee a change in my financial aid award.

I understand that I will receive an email notifying me of any change in my Cost of Attendance once this appeal has been processed.

**I attest to the accuracy of the information provided.**

\_\_\_\_\_  
**STUDENT SIGNATURE**

\_\_\_\_\_  
**DATE**

**For Department Use Only:**

Budget Maint \_\_\_\_\_ Award Entry \_\_\_\_\_ Date Complete \_\_\_\_\_

Email \_\_\_\_\_ Comment \_\_\_\_\_ Completed By \_\_\_\_\_

**Office of Student Financial Aid**

3901 Rainbow Blvd. | Mail Stop 4005 | Kansas City, KS 66160 | [financialaid@kumc.edu](mailto:financialaid@kumc.edu) | 913-588-5170 (P) | 913-588-8841 (F)