2019-2020
Request for Dependent Care Allowance

DCW20

Please Use Black or Blue Ink

Student Name:	OSU Banner ID ("A" plus 8 digits)
	A

Instructions:

Federal law allows financial aid offices to consider the costs incurred by a student in providing care for a dependent. The term "dependent" applies not only to children, but can include, for example, an elderly or disabled adult (including the student's spouse). To qualify, the dependent must be included in the student's household size. We can include these costs when determining a student's federal student aid eligibility **when the costs are not covered by other sources**. To apply for the allowance you must provide our office with:

1. Name(s) and age(s) of your dependent(s) (Section 1, below);
2. Documentation of the type(s) of care that is necessary for your dependent(s) and the non-reimbursed costs you are incurring for the services provided. **Please have your dependent care provider(s) complete Section 2 located on the back of this form (one per provider);**
3. Documentation that your spouse is also attending college (submit class schedule) and/or is employed (submit copy of most recent pay stub, work schedule or letter from employer).

The allowance is provided to the family; if you are provided the allowance, your spouse is not entitled to the same allowance.

Section 1 *(to be completed by the student):*

Academic Term:* ❑ Fall 2019 **OR** ❑ Spring 2020 **OR** ❑ Summer 2020

*** A new request is required for each academic term and will not be accepted prior to the 3rd week of classes each term.**

Dependent(s): If you have more than four (4) dependents, please list the following information on an additional piece of paper.

Name of Dependent	Relationship to You	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital Status: Are you married? ❑YES ❑NO

If YES, will your spouse be enrolled for the 2019-2020 academic year? ❑YES ❑NO

If YES, your spouse's name: _____, OSU Banner ID if OSU student: A_____,

and the name of the college he/she will attend in 2019-2020: _____.

Loan Request: ❑ Subsidized Loan ❑ Unsubsidized Loan ❑ Approved Graduate PLUS Loan

Amount Requested (specify dollar amount): $_____

Certification: *The individual(s) referenced above are part of my household while I am attending Oklahoma State University for the 2019-2020 academic year. The expense(s) given above, which I am incurring, are necessary to provide care to my dependent(s). Without these services, I could not attend Oklahoma State University. I agree to provide the Office of Scholarships and Financial Aid additional information if necessary. I acknowledge that I may be liable for repayment of any financial assistance received if the information that I am providing is found not to be totally accurate.*

I authorize the OSU Office of Scholarships and Financial Aid to contact my dependent care provider(s) if further information is required.

_____ _____

Student's Signature *(electronic signature not acceptable)* Date

Please have your dependent care provider(s) complete Section 2 located on the next page of this form.

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Student's Name:_____ **Banner ID**: A_____

Instructions to the Dependent Care Provider:

Financial aid offices can include costs incurred by a student in providing care for a dependent when determining a student's federal student aid eligibility **when the costs are not covered by other sources.** To consider these costs, the OSU Office of Scholarships and Financial Aid requires documentation of the type(s) of care necessary for the dependent(s) and the non-reimbursement costs paid by the student per week. **Please submit one form per provider.**

Section 2 *(to be completed by the **dependent care provider**):*

Name of Dependent Care Agency: _____

Name/Title of Agency Contact: _____

Telephone Number of Contact Person: (_____)_____

Name of Child	Dates of Attendance	Days/Times per Week	***Non-reimbursed Costs* Paid by the Student per Week**
			$
			$
			$
			$

***Non-reimbursed costs are those paid directly by the student to the provider. Do <u>not</u> include payments made to the provider by the Department of Human Services or any other sources.**

CERTIFICATION: I hereby certify that the information reported above is complete and correct.

_____ _____
Childcare Provider Signature *(electronic signature not acceptable)* Date

_____
Childcare Provider Printed Name

Return to:
Office of Scholarships and Financial Aid
119 Student Union, Stillwater, OK 74078-5061
Fax: (405) 744-6438 *(if you fax, please do not mail the form)*

Questions?
Email: finaid@okstate.edu
Phone: (405) 744-6604
Web: financialaid.okstate.edu