If you will be paying for dependent care expenses during the 2015-16 academic year and you are requesting an adjustment to your cost of attendance, **you and your care provider must complete and sign this form.** If you use more than one care provider, please complete a form for each provider. If someone else is paying for your dependent care expenses or if you are fully reimbursed for expenses, you are not eligible for an adjustment and should not complete this form.

Do you receive public assistance for dependent care? ☐ YES ☐ NO

If yes, please include with this form a signed statement from your public assistance agent indicating the monthly amount you receive for dependent care.

Is your dependent care provider a family member or relative? ☐ YES ☐ NO

If yes, this form must be notarized below.

<table>
<thead>
<tr>
<th>Dependent's Name</th>
<th>Dependent's Age</th>
<th>Cost of Dependent Care per month</th>
<th>Mark term(s) care will be provided for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fall 2015    Spring 2016    Summer 2016</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL Family Monthly Dependent Care Cost $ ________________

Use additional sheet if needed.

**Care Provider Signature Section**

__________________________________________
PRINTED NAME OF DEPENDENT CARE PROVIDER

(_____)_______
PROVIDER TELEPHONE NUMBER

I hereby verify that the costs and names of dependents listed on this form for which I / my center provides care are accurate and true to the best of my knowledge.

__________________________________________
SIGNATURE OF DEPENDENT CARE PROVIDER

DATE

**Student Signature Section**

By signing this form, I certify that all information is complete and correct.

__________________________________________
STUDENT SIGNATURE

DATE

**Notary Signature Section**

If your dependent care provider is a family member/relative, this form must be notarized.

__________________________________________
NOTARY SIGNATURE (required only if care provider is a family member/relative)

DATE

**Return form to:**

UW Colleges Student Financial Aid Office

780 Regent St, Suite 130

Madison, WI 53715-2635