



OREGON HEALTH & SCIENCE UNIVERSITY
2011-12 CHILD CARE PROVIDER STATEMENT

Dependent care expenses may be taken into consideration as educational costs. If you are incurring these expenses, complete this form at any time during the academic year to request a financial aid review and possible budget increase for these costs.

Institutional policy does dictate maximum amounts for budget increases. The maximum amounts allowed are included in the 'Student Financial Aid Explained' document on the www.ohsu.edu/finaid webpage.

Student Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Children Receiving Child Care

Name \_\_\_\_\_ Age \_\_\_\_\_
Name \_\_\_\_\_ Age \_\_\_\_\_
Name \_\_\_\_\_ Age \_\_\_\_\_
Name \_\_\_\_\_ Age \_\_\_\_\_

\*\*To be completed by the Provider:
Hours per Week of Care: \_\_\_\_\_ Rate of Charge: \_\_\_\_\_ Total Monthly Cost: \_\_\_\_\_
Number of Months Childcare Will Be Provided During the School Year (From June 2011 through June 2012): \_\_\_\_\_
Name of Child Care Provider: \_\_\_\_\_ (Company or Individual)
I certify that I, or my company, provide childcare services for the children listed above for the academic year specified. I further certify that the information regarding hours of care and rate of charge provided above is accurate.
Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

I, the student, parent of the above named children, certify the information provided here is true and correct. I understand that I must notify the Financial Aid Office if my childcare costs change during the school year. Attach documentation of billing or payment for childcare services specified. This request will not be processed without documentation of payment.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

CCPS

Please Print and return the form to:
OHSU Financial Aid Office,
3181 SW Sam Jackson Park Road, Mail Code L109
Portland, OR 97239-3098

For Office Use:
\_\_\_\_\_ HHS
\_\_\_\_\_ Months