2019-20 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. Increased funding will be offered as available based on individual student eligibility and in accordance with federal, state, and institutional regulations or policies.
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. Please do not use this form to report your child support payments. We are unable to provide child care costs adjustments if the provider is the parent or legal guardian of the child.

Student Name_____ **Student ID#**_____

Child(ren) Receiving Child Care:

Name	Age	Total Monthly Cost of Care

To be completed by the Provider

Months child care will be provided during the school year: _____ through _____
(mm/yy) (mm/yy)

Name of child care provider (company or individual):_____

I certify that I, or my company, provide child care services for the child(ren) 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 child(ren), certify the information provided here is true and correct. I understand that I must notify the Financial Aid Office if my child care costs change during the school year.

- ☐ **I have attached documentation of billing or payment for child care services specified. This request will not be processed without documentation of billing or payment.**

Student Signature_____ **Date**_____

Please print and return the form to: **APCCPS**

Preferred Method - Email: finaid@ohsu.edu

OHSU Financial Aid Office
3181 SW Sam Jackson Park Road, Mail Code L109
Portland, OR 97239-3098
Fax: 503.494.4629

For Office Use:
_____ HHS
_____ EFC Months