If you will be paying for dependent care expenses during the 2016-2017 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 2016     Spring 2017  Summer 2017</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 (handwritten, not typed) ________________________________

DATE ____________________________

**Student Signature Section**

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

STUDENT SIGNATURE (handwritten, not typed) _________________________________________________

DATE ____________________________

**Notary Signature Section**

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

NOTARY SIGNATURE (required if care provider is family/relative) (handwritten, not typed) ____________________________

DATE ____________________________

Submit form to: UW Colleges Student Financial Aid Office
780 Regent St, Suite 130
Madison, WI 53715-2635