Student Name: _______________________________  Student ID or SSN: ________________

If you will be paying for dependent care expenses during the 2017-18 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 2017  Spring 2018  Summer 2018</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 $ __________

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