Dependent Care Allowance Request Form

National University of Health Sciences
Office of Student Financial Aid

Federal regulations permit the Financial Aid Office to increase a student's educational cost of education budget by creating an allowance for costs expected to be incurred for dependent care. The amount of the allowance is to be based on the number and age of such dependents and should not exceed a reasonable cost. The reasonable cost basis is the child care cost of Delphi Academy in Lombard, otherwise referred to as the "community standard"; however, all requests will be reviewed to determine reasonableness.

The dependent care allowance is for the express purpose to enable the student to attend class, internship programs, or some other educational activity required by the respective program of study to complete the required program of study. Additional costs for maintenance are already included in the budget and can be reviewed with a financial aid counselor.

The dependent care allowance will only be approved for the student actually paying the expense; both parents of a two-student household may NOT use the same allowance.

SECTION A: *To be Completed by student requesting a Dependent Care Allowance component in financial aid award. A separate form is required if using different child care provider for different child(ren).*

Name of Child	Age	Weekly Rate
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. I/We have certify that I/we __ have __ have not applied for assistance from the Illinois Department of Human Services Child Care Assistance Program (CCAP) for the child(ren) listed above for the same period of time.
2. I/We certify that I/we __will __will not apply for assistance for the child(ren) listed above for the same period of time.
3. I/We understand that both parents cannot request a dependent care allowance for the same dependent(s).
4. I/We certify that all of the information on this form is complete and correct

Student Signature _____ Date _____

Spouse Signature _____ Date _____

SECTION B: *To be completed by the dependent care provider*

Care provided for each child above	From	To	Weekly Rate
Child's Name _____	___/___/___	___/___/___	$ _____
Child's Name _____	___/___/___	___/___/___	$ _____
Child's Name _____	___/___/___	___/___/___	$ _____
Child's Name _____	___/___/___	___/___/___	$ _____

I confirm that the expected dependent care expenses I have listed above are an accurate projection of expected dependent care expenses and are not being paid for by any source other than the student. In addition, I confirm that these child(ren) will be in my care for the dates listed above.

Signature _____ Date _____

Printed Name _____ Phone Number _____

Address _____ City _____ State _____

FAO Review _____ Approved ___ Denied ___ Date _____