THE UNIVERSITY OF CHICAGO
PRITZKER SCHOOL OF MEDICINE

OFFICE OF FINANCIAL AID

924 East 57th Street, Suite 104Chicago, IL 60637
Phone: 773-702-1938
Fax: 773-834-5412

2019-2020 DEPENDENT CARE BUDGET REQUEST FORM

Students who have dependents other than a spouse (such as young children or elderly dependent parents) for whom they have financial responsibility are eligible to apply for supplemental loan assistance to help offset the costs for dependent care. Allowable costs include day care expenses, child care services, etc. The amount of the supplement is based on actual costs incurred within limits for what is considered fair and reasonable rates.

Please return the completed form below along with the second-party documentation of your actual dependent care costs to our office. Documentation should include (but not be limited to) a minimum of one billing statement from each service provider along with a projection of total costs for your academic year. A letter from the service provider can be submitted in lieu of a billing statement provided that it is on letterhead of the service provider and includes the address and telephone number. Remember to have each service provider sign and date the certification section provided below.

All requests for dependent care budget increases for the 19-20 academic year must be made by June 1, 2020.
The additional financial need will be met first with Unsubsidized Stafford Direct Loans, then with Graduate PLUS loans.

STUDENT LAST NAME: _____ FIRST NAME: _____

STUDENT ID #: _____ DEGREE PROGRAM: _____
(e.g. MD, MSTP, MD/MBA, etc)

EXPECTED GRADUATION DATE: _____

MARITAL STATUS: _____ SPOUSE/PARTNER INCOME: _____
(e.g. Single, Married, Domestic Partner)

DEPENDENT(S) RECEIVING CARE:

NAME: _____ AGE: _____ RELATION: _____

NAME: _____ AGE: _____ RELATION: _____

NAME: _____ AGE: _____ RELATION: _____

CERTIFICATION: I certify that this information stated in this request is true and accurate. I have attached all required documentation.

SIGNATURE: _____ DATE: _____

OFFICIAL USE ONLY: Approved: ☐ Yes ☐ No Eligible Dependents: _____ Max Increase: _____

Approved by: _____ Date: _____

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SERVICE PROVIDER 1:

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

WEEKLY CHARGE OF SERVICE: $_____ (Attach copy of billing statement or canceled check for documentation)

DATE OF EXPENSES: from _____ to _____

PROVIDER CERTIFICATION: I will provide/have provided dependent care services for the above named individual(s). I certify that the information reported above is correct.

PROVIDER SIGNATURE: _____ DATE: _____

REQUIRED DOCUMENTATION: At least one billing statement/invoice/contract/canceled check.

SERVICE PROVIDER 2:

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

WEEKLY CHARGE OF SERVICE: $_____ (Attach copy of billing statement or canceled check for documentation)

DATE OF EXPENSES: from _____ to _____

PROVIDER CERTIFICATION: I will provide/have provided dependent care services for the above named individual(s). I certify that the information reported above is correct.

PROVIDER SIGNATURE: _____ DATE: _____

REQUIRED DOCUMENTATION: At least one billing statement/invoice/contract/canceled check.