

## Dependent Care Allowance Request

**FILING DEADLINE 4/15/20**

STUDENT ID	LAST NAME	FIRST NAME	PHONE NUMBER (with area code)
PLEASE PRINT IN BLACK INK			

I certify that my child/dependent care expenses for **2019-2020** academic year while I attend school are:

Child/Dependent's Name	Age	(Sept. 2019 - Dec. 2019)	(Jan. 2020 - May 2020)
		\$ Amount (fall semester)	\$ Amount (spring semester)
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

My spouse is also a Fresno State student. Spouse's Name: \_\_\_\_\_ ID # \_\_\_\_\_

**NOTE: Documentation must reflect expenses for the period you are requesting aid. (Max. = \$3,300 / academic year (\$1,650/ semester))**

Attached is a copy of my care provider contract or copies of my cancelled checks. I pay a total of \$ \_\_\_\_\_ per \_\_\_\_\_.

**OR**

Part II of this form has been completed by the care provider.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

### PART II- CARE PROVIDER

Name \_\_\_\_\_ Address \_\_\_\_\_

Care provided from \_\_\_\_\_ through \_\_\_\_\_ Amount Charged \$ \_\_\_\_\_  
date date (circle one) per week/ month/ flat rate.

**I certify the above charges are for child/dependent care provided during the 2019-2020 academic year for the student named on the top of this form. I also certify that these charges are true and correct.**

Provider Signature \_\_\_\_\_ Phone Number \_\_\_\_\_ Date \_\_\_\_\_

#### FOR OFFICE USE ONLY

**APPROVED**  Your cost of attendance has been increased by \$ \_\_\_\_\_.  
 A revision to your award is being processed.  Your award has not changed (see comments)

**DENIED** Reason: \_\_\_\_\_

**RETURNED** Information/documentation required: \_\_\_\_\_

**OTHER/COMMENTS** \_\_\_\_\_

Financial Aid Counselor/Technician Signature \_\_\_\_\_ Date \_\_\_\_\_