

University of Oklahoma  
Health Sciences Center  
Student Financial Aid

1106 N. Stonewall, Room 301  
Oklahoma City, Ok 73117  
Fax # 405-271-5446

# Dependent Care Verification

Name: _____		
Last	First	MI
EmpID: _____	STUDENT ID: _____	

You may be able to have your budget increased if you have dependent children (ages 12 and under, for whom you provide at least 50% support) and must pay child-care costs while attending classes. Your budget will be increased by a flat amount per child listed on this form.

I certify that I pay child-care expenses for the following dependents:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Name of Child-Care Provider:** \_\_\_\_\_

Last 4 digits of Provider's SSN or Tax ID #: \_\_\_\_\_ Provider's Phone \_\_\_\_\_

Will any other agency or resource provide child-care support?     YES     NO

If yes, identify source: \_\_\_\_\_ Amount of support per year: \$ \_\_\_\_\_

**I hereby authorize the financial aid office to verify the above information:**

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

\_\_\_\_\_  
Date