

**2009-10 REQUEST FOR COST OF ATTENDANCE BUDGET INCREASE
FOR DAY CARE EXPENSES**

Name: _____ WSU ID #: _____ Yr in Med School: _____

Date: _____ Phone: (____) _____ Email: _____

- **You may request that Day Care expenses be added to your Cost of Attendance if:**
 - a. You are a single parent OSFA will approve **100%** of reasonable, documented expenses.
 - b. Your spouse/other parent residing in household is either a full-time student, or is employed outside of the home for a minimum of 30 hours per week, OSFA will approve **50%** of reasonable, documented expenses.
- **OSFA will determine eligibility on a case-by-case basis.**

PART I -- To be completed by Day Care Provider:

1. Name of Day Care facility, or provider*: _____
(*If you are using a non-licensed in-home provider, you must have this form **notarized**.)

a. License # of facility, or provider: _____

b. Phone # of facility, or provider: _____

2. Name of child/dependent being care for: _____ Weekly Cost, including any discounts for additional children/dependents:

1st: _____ \$ _____

2nd: _____ \$ _____

3rd: _____ \$ _____

4th: _____ \$ _____

\$ _____ = **Total Weekly Cost**

Signature of Day Care Provider: _____ Date: _____

PART II -- To be completed by Student:

1. **Student marital status:** a. Single _____ b. Married _____ c. Other _____

2. **Complete if married,** or if both parents reside in the same household:

a. Spouse/Other Parent name: _____

b. Is Spouse/Other Parent employed for a minimum of 30 hours per week?

Yes: _____ No: _____

c. Does Spouse/Other Parent attend school?

Yes: _____ No: _____

d. If yes, answer the following questions: **(Attach a copy of their class schedule.)**

i. Name of institution where enrolled: _____

ii. Specify if graduate or undergraduate student: _____

iii. Expected number of credit hours for each term: Fall 2009 _____ Winter 2010 _____

3. **Additional Financial Resources:** (List any sources on non-taxed income, or benefits you will receive this academic year such as Family Independence Agency, Work First, Social Security, Child Support, etc.)

a. Source of Income

b. Monthly Amount Expected

\$ _____

\$ _____

\$ _____ = **Annual Total**

4. **Statement of Understanding:** (Read and initial line.)

_____ I understand that changes in my enrollment status could result in a reduction or cancellation of my award.

_____ I am aware that I must report any changes in dependent care arrangements or enrollment status to OSFA.

_____ I understand that OSFA may request additional documentation before approving this request.

_____ I certify that all information reported on this form is true to the best of my knowledge.

_____ I give permission to the Day Care provider listed to release the information requested.

5. **Total Day Care Expenses being requested as a 2009-2010 Cost of Attendance increase:**

\$ _____

Signature of Spouse/Other Parent: _____ **Date:** _____

By Submitting this document, I am also requesting an increase to my financial aid award, via the attached Loan Request/Revision form for:

Federal DIRECT Subsidized/Unsubsidized Stafford Loan **Federal DIRECT Graduate PLUS Loan**

Signature of Student: _____ **Date:** _____