UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
CHILD CARE EXPENSE FORM
2019-2020

Last Name:	**First Name:**	**MI:**
Local Address:		**Phone:**
City:	**State:**	**Zip:**
Date of Birth:	**EMPL ID:**	**SSN:**

Please provide Name, Address, and Telephone Number of Provider(s) of Child Care:

	Phone #:		Phone #:

Please list the names and ages of your dependent children for whom you will pay expenses for child care:

Name	Age	Name	Age

Amount paid per week in 18-19?: _____	Number of weeks childcare was used in 18-19? _____
Amount to be paid per week in 19-20? _____	Number of weeks childcare will be used in 19-20? _____

Please explain any special circumstances such as an announced increase or decrease in costs between July 1, 2019, and June 30, 2020

I certify that the above information is true and accurate, and that I will notify the Financial Aid office of any changes that occur during the academic year.

Signature	Date

OFFICE USE ONLY:

POE: _____ Authorized by: _____ Date: _____

Enrollment dates Fall:_____ Weeks in Fall: _____ Total increase for Fall: _____

Enrollment in Spring: _____ Weeks in Spring:__ _____ Total increase for Spring: _____

Enrollment in Summer: _____ Weeks in Summer:__ _____ Total increase for Summer: _____