UNIVERSITY OF MASSACHUSETTS CHAN **MEDICAL SCHOOL**
CHILD CARE EXPENSE FORM
2024-2025

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 23-24?: _____	Number of weeks childcare was used in 23-24? _____
Amount to be paid per week in 24-25? _____	Number of weeks childcare will be used in 24-25? _____

Please explain any special circumstances such as an announced increase or decrease in costs between July 1, 2024, and June 30, 2025

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: _____