UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
CHILD CARE EXPENSE FORM
2016-2017

Your Name:	Your Social Security number:

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 15-16	
Number of weeks childcare was used in 15-16	

Amount to be paid per week in 16-17	
Number of weeks childcare will be used in 16-17	

Please explain any special circumstances such as an announced increase or decrease in costs between July 1, 2016, and June 30, 2017

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:

PF Communications _____ PF Budget _____ POE/Program _____

Weeks in Spring _____ Weeks in Fall _____ Authorized by: _____ Date: _____