TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Financial Aid Office

Child Care Expense Form

Name: _____ Student ID#: _____

Address: _____

School: _____ Classification: _____ □Full time, □Half time □ Less than half time

If married, please provide spouse information below.

Spouse's Name: _____ Is spouse attending college? □ Yes □ No If yes,

Spouse's University _____ □Full time, □Half time □ Less than half time

Is spouse employed? □ Yes □ No If yes, Place of employment: _____

How often paid? □Monthly, □ Bi-monthly, □ Every week

Child care needed for the following semesters: Summer _____ Fall _____ Spring _____ (indicate year)

The information on this form is used to validate childcare expenses for audit purposes. The name, address, telephone and signature of the provider must be completed. Please attach a copy of paid monthly statement.

Child Care Expense Verification (to be completed by child care provider)

Name of Child Care Provider: _____ Phone _____
Address: _____

Child care began or will begin: _____ Child care will end: _____

Child's Name	Child's Age	Number of hours per day	Weekly rate	Monthly Total

As a child care provider for this student's child(ren), I certify the about stated information is true and correct to the best of my knowledge.

Signature of Child Care Provider: _____ Date: _____

Student Certification

I hereby certify that all information reported on this document is true, complete and accurate to the best of my knowledge. I understand that any false statement or misrepresentation will be cause for denial, reduction, cancellation and/or repayment of financial aid.

Student Signature: _____ Date: _____

Student E-mail: _____

Financial Aid Office Use Only	
Amount Approved:	
Comment:	
Financial Aid Advisor Signature:	Date:
Associate Director Signature:	Date: