



BOISE STATE UNIVERSITY

STUDENT AFFAIRS

Financial Aid and Scholarships

Financial Aid and Scholarships
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2017-2018

BUDGET INCREASE - DEPENDENT CARE

STUDENT NAME: ID#: PHONE:

(Budget increases are not processed at the beginning of each semester: Aug. 7 - Sept. 5, 2017 and Dec. 18, 2017 - Jan. 24, 2018)

Deadlines for submitting this form:

Nov. 1, 2017 - if fall 2017 is your last semester at Boise State

April 1, 2018 - if you will attend spring 2018 at Boise State

Summer only students - whichever date is earlier: 3 weeks before the end of your last session, or July 15, 2018

Instructions:

- 1. Complete student section and sign.
2. Ask dependent care provider to complete section 2 and sign.
3. Attach documentation of charges or payments, such as bills or receipts.

If applicable, also attach documentation of agency assistance, such as ICCP summary statements. (If you are interested in requesting help from ICCP, call the Idaho CareLine at 2-1-1 or 1-800-926-2588.)

If daycare services are being provided by a friend, family member or anyone other than a state licensed daycare provider, please provide documentation in the form of cancelled checks or a tax return showing that the untaxed income has been reported to the IRS.

1. STUDENT SECTION

Which semester(s)? Both Fall and Spring Fall 2017 only Spring 2018 only Summer 2018 only

If approved, what type of additional aid are you seeking? Please indicate your intent:

Direct or Perkins Loan PLUS Loan Alternative Loan Work-Study

Is your child's other parent also a student? No Yes

If yes, where is co-parent enrolled? Boise State Other (specify):

Co-parent's name: and SSN/ID:

I certify the accuracy of the above information and authorize my dependent care provider to release the information requested.

Student Signature: Date:

2. DEPENDENT CARE PROVIDER SECTION (Use a separate form for each provider.)

Name of dependent care facility: Phone number:

Table with columns: Name of Dependent, Age, CHARGES (Weekly/Monthly), SOURCE OF PAYMENT (Amount paid by Student, Amount paid by ICCP, Other)

I certify the above information is correct.

Signature of dependent care provider

Print name

Date