DCW26

2025-2026
Request for Dependent Care Allowance

Please Use Black or Blue Ink

Student Legal Name:	OSU Student ID (8 digits)
	A

Instructions:

Federal law allows financial aid offices to consider reasonable costs incurred by a student in providing care for a dependent. The term "dependent" applies not only to children, but can include, for example, an elderly or disabled adult (including the student's spouse). To qualify, the dependent must be included in the student's family size, and **costs can't be covered by other sources.** To apply for the allowance, you must provide our office with:

1. Name(s) and age(s) of your dependent(s) in Section 1, below;
2. Documentation of the type(s) of care that is necessary for your dependent(s) and the non-reimbursed costs you are incurring for the services provided, which include the following:
   a. **Section 2 completed by your dependent care provider (one per provider) located on the back of this form,**
   b. **A copy of your most recent invoice(s) from the indicated dependent care provider(s)**
3. Documentation that your spouse is also attending college (submit a current class schedule) and/or is employed (submit a copy of the most recent pay stub, work schedule, or letter from employer with work schedule).

The allowance is provided to the family; if you are provided the allowance, your spouse is not entitled to the same allowance.

Section 1 *(to be completed by the student):*

Academic Term:* ❑ Fall 2025 **OR** ❑ Spring 2026 **OR** ❑ Summer 2026

*** A new request is required for each academic term and will not be accepted before the 3rd week of classes each term.**

Dependent(s): If you have more than four (4) dependents, please list the following information on an additional piece of paper.

Name of Dependent	Relationship to You	Age

Marital Status: Are you married? ❑YES ❑NO

If YES, will your spouse be enrolled for the 2025-2026 academic year? ❑YES ❑NO

If YES, your spouse's name: _____, OSU Student ID if OSU student: A_____,

and the name of the college they will attend in 2025-2026: _____.

Loan Request: ❑ Subsidized Loan ❑ Unsubsidized Loan ❑ Approved Graduate PLUS Loan

Amount Requested (specify dollar amount): $_____

Certification: *The individual(s) referenced above are part of my family as defined by the FAFSA, while I am attending Oklahoma State University for the 2025-2026 academic year. The expense(s) given above, which I am incurring, are necessary to provide care to my dependent(s). Without these services, I could not attend Oklahoma State University. I agree to provide the Office of Scholarships and Financial Aid with additional information if necessary. I acknowledge that I may be liable for repayment of any financial assistance received if the information that I am providing is found not to be totally accurate.*

I authorize the OSU Office of Scholarships and Financial Aid to contact my dependent care provider(s) if further information is required.

_____ _____

Student's Signature *(Stylus or ink pen only)* Date

Student's Legal Name:_____

Student ID: A_____

Instructions to the Dependent Care Provider:

Financial aid offices can include reasonable costs incurred by a student in providing care for a dependent when determining a student's federal student aid eligibility, **when the costs are not covered by other sources.** To consider these costs, the following documentation of the type(s) of care necessary for the dependent(s) and the non-reimbursed costs paid by the student per week **is required:**

- **The form below is completed by the provider, one form per provider**
- **A copy of the most recent invoice(s) from the indicated dependent care provider(s)**

Section 2 *(to be completed by the **dependent care provider**):*

Name of Dependent Care Agency: _____

State-Issued Provider Number or Agency's EIN (required)_____

Name/Title of Agency Contact: _____

Telephone Number of Contact Person: (_____)_____

Name of Dependent	Dates of Attendance	Days per Week	Hours per Day	**Non-reimbursed Costs* Paid by the Student per Week
				$
				$
				$
				$

***Non-reimbursed costs are those paid directly by the student to the provider. Do <u>not</u> include payments made to the provider by the Department of Human Services or other sources.**

CERTIFICATION: I hereby certify that the information reported above is complete and correct.

_____ _____
Childcare Provider Signature *(Stylus or ink pen only)* Date

_____
Childcare Provider Printed Name

Return to:
Office of Scholarships and Financial Aid
119 Student Union, Stillwater, OK 74078-5061
Fax: (405) 744-6438 *(if you fax, please do not mail the form)*

Questions?
Email: finaid@okstate.edu
Phone: (405) 744-6604
Web: financialaid.okstate.edu