



Office of Financial Aid & Scholarship Management  
 1005 Dr. DB Todd Jr, LRC Bldg., Suite 609  
 Nashville, TN 37208  
 615-327-6826 | finaid@mmc.edu

### Dependent Care Expense Worksheet

**Student Name:** \_\_\_\_\_ **M #:** \_\_\_\_\_

**Program:**  Medicine  Dental  Graduate Studies  SACS  Global Health

**Term(s) for Review:** Fall 20\_\_\_\_\_ Spring 20\_\_\_\_\_

Please provide the following information about expenses incurred for dependent members of your household who are under the age of 13. This worksheet must be signed by both the student and dependent care provider to be considered in review of a request for a Cost of Attendance.

Name of Dependent	Age	Relationship	Daycare Provider	Weekly Rate

Source of dependent care subsidy or assistance (if applicable): \_\_\_\_\_

Amount of dependent care subsidy or assistance: \_\_\_\_\_

I certify that the information provided on this form is accurate and complete as of this date. I understand that this document submitted in conjunction with request for a review of my cost of attendance is not guaranteed to result in a change to my financial aid eligibility and does not release me from my payment of any balance due on my student account. **I have attached a letter on letterhead from the daycare facility.**

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relation to Student (if applicable): \_\_\_\_\_