CHILD CARE EXPENSE VERIFICATION

MT. HOOD COMMUNITY COLLEGE
OFFICE OF FINANCIAL AID
26000 SE Stark St., Gresham, OR 97030
503-491-7262 FAX: 503-491-7379

APPLICANT'S NAME_____ SSN or MHCC ID# _____

ADDRESS _____ APT# _____

CITY _____ ST ____ ZIP _____ PHONE ( ) _____

I will need assistance during: ☐ Summer ☐ Fall ☐ Winter ☐ Spring

I would not be able to attend college if I did not have this childcare for my child(ren). I receive $_____ per month from _____ to pay for childcare.
(Agency)

(**Enter Zero if no money is provided.** If zero, and you receive ADC benefits, provide current ADC statement regarding childcare subsidies.)

IF YOU HAVE MORE THAN ONE CHILD CARE PROVIDER, YOU MUST TURN IN A SEPARATE CHILD CARE EXPENSE VERIFICATION FORM FOR EACH PROVIDER.

NAMES AND AGES OF CHILDREN REQUIRING CHILD CARE:

NAME	AGE	NAME	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STUDENT SIGNATURE _____ **DATE** ____/____/____

Note: If a relative of yours or the childs(rens) is the provider, or if the provider has the same address as you, you must provide copies of three months of cancelled checks or money orders.

PROVIDER SECTION

(To be completed by provider only)

PROVIDER'S NAME _____

BUSINESS NAME _____

STREET ADDRESS _____ PHONE ( ) _____

CITY _____ STATE _____ ZIP _____

Average child care cost PER MONTH for this applicant is $ _____

I am ☐ I am not ☐ related to the child(ren).

PROVIDER SIGNATURE _____ DATE ____/____/____