CHILD/ELDER CARE REQUEST FOR PROFESSIONAL JUDGEMENT

Student Name: ____ ID: 770-______________

Permanent Street Address: ____

City/State/Zip: ____

Permanent Phone #: (_____) ______-________ Academic Year: ______-______

Budget Modification (Circle one of the following.)

- Child Care Expenses – include copy of bill
- Other Dependent Care Expenses – include copy of receipts and/or bill
- Other ____

Your request will need to include the following:

- **Child/Elder Care Form (see attached)**
- **Copy of monthly bill and or receipts to support circumstance**
- **Signed & dated DETAILED (dates and amounts – a financial timeline) statement explaining current situation and the reason for requesting a Professional Judgment**

I am requesting that the Financial Aid Director at Helena College University of Montana consider my circumstances to determine if I may be eligible for a professional judgment according to the Department of Education Federal Regulations. This determination may allow my financial aid eligibility to change at the Helena College University of Montana only. I agree to provide any documentation requested by the Financial Aid Director if it can be obtained. I understand that this decision is made by the Financial Aid Director based upon documentation I supply and that any professional judgment decisions are final.

Student Signature _______________________________________ Date _________________

This form and any required/requested documentation must be given to the Helena College Financial Aid Office prior to any professional judgment being granted.

FOR QUESTIONS CALL: FINANCIAL AID OFFICE, Helena College, 1115 N. Roberts Street, Helena, MT 59601
406-447-6916, www.helenacollege.edu
RETURN DOCUMENTATION TO: FINANCIAL AID OFFICE, Helena College, 1115 N. Roberts Street, Helena, MT 59601, or fax to: 406-447-6397.

Child/Elder Care Expenses

____ ________________

Last Name First Middle Int. Student ID/SS#

____ ________________

Spouse's Name Last First Student ID/SS#
(If Applicable)

You indicated that you will pay child/elder care expenses between (month/year) _______________ and (month/year) ______________.

Dependent Name	Age	Costs Per Month	Care Provider	Signature of Provider	Phone #

I certify that:

1. None of the expenses listed on this form will be covered by another agency, and I will be paying these expenses myself.
2. The information on this form is true and accurate to the best of my knowledge, and I will provide proof of payment, if required.
3. If married, my spouse has not, and will not, claim these expenses.

____ ________________

Student Signature Date

Warning: If you purposely give false or misleading information to help establish eligibility for federal student aid, you may be subject to $10,000 fine, or prison sentence, or both.