



OFFICE OF FINANCIAL AID  
PHONE: (845) 257-3250  
FAX: (845) 257-3568

MAIL THIS FORM TO:  
SUNY New Paltz Financial  
Aid Office  
200 Hawk Drive  
New Paltz, NY 12561-2437

**FORM CS-Dependent  
2016-2017**

Student's Name \_\_\_\_\_

Student ID \_\_\_\_\_

1) Did the parent(s) with whom you filed the FAFSA, pay child support in 2015?

☐

Yes

☐

No

2) If yes, please provide the name of person(s) to whom the child support was paid:

\_\_\_\_\_

3) If yes, please provide the name of person(s) who paid child support:

\_\_\_\_\_

4) List the name(s) of all child(ren) and total amount paid in 2015:

Name:

Age:

Total Paid in 2015:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CERTIFICATION STATEMENT AND SIGNATURES:

We certify that all the information reported on this form is complete, and accurate to the best of my knowledge. We understand that any false statements could be cause for denial, reduction, withdrawal, or repayment of my financial aid.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date