

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
2018-2019**

Student's Name _____

Student ID _____

1) Did the parent(s) with whom you filed the FAFSA, pay child support in 2016?

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 2016:

Name:	Age:	Total Paid in 2016:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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