LOW INCOME PROTECTION PLAN

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DEPENDENT CARE EXPENSES COVER SHEET

Please attach official documentation of these expenses (i.e. copies of invoices or receipts or a letter from the provider outlining the costs) and use as many sheets as necessary if you have more than 3 providers. Expenses must be split by dependent. Your expenses will not be taken into account without documentation.

LIPP Participant's Name: _____

Gross Annual Income of Co-Parent, if Applicable: _____

Monthly Educational Loan Payments of Co-Parent if Applicable: _____

Please upload supporting documentation including required monthly payment and payment history for review.

Provider Name:	
Dependent Receiving Care:	
Start Date of Care:	
End Date of Care:	
Cost (*please specify if this is weekly, monthly, or for a set date range*):	

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End Date of Care:	
Cost (*please specify if this is weekly, monthly, or for a set date range*):	

Please use this space to report any changes that occurred during the Jan-June 2025 period, including the date of birth(s) of any dependents born within that period:

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