LOW INCOME PROTECTION PLAN

HARVARD LAW SCHOOL, WASSERSTEIN SUITE 5027
CAMBRIDGE, MASSACHUSETTS 02138
TEL: (617) 495-0643
LIPP@LAW.HARVARD.EDU

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*):	

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*):	

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*):	

Please use this space to report any changes that occurred during the July-Dec 2026 period, including the date of birth(s) of any dependents born within that period:

_____

_____

_____

_____