

If you need assistance completing this form, please contact us at 817-272-3561.



Office of Financial Aid

Office Use Only

2026-2027 Dependent Verification of Family Member(s)

Office: UAB, Room B17 Phone: 817-272-3561 Fax: 817-272-3555

Mail: PO Box 19199, Arlington, TX 76019

Document Upload: uta.edu/finaidupload

Student's Name:

UTA ID:

Below, please check the box and list the name, age and your relationship with all members of your family. **Members of your family include you, your parent(s), your siblings, and any other persons who will be receiving more than half of their financial support from your parent(s) for the entire academic year (July 1, 2026 - June 30, 2027).**



By checking this box, I attest to the fact that all persons below receive more than half of their financial support from my parent(s).

First and Last Name	Age	Relationship to Student
Student:		Self

☐ Check here if more space is needed and attach an additional sheet with the required information and student's name/ID.

Certification and Signature(s)

Each person signing below certifies that the information reported on this form is complete and correct.

Student's Handwritten Signature (required)

Date

Parent's Handwritten Signature (required if dependent)

Date

WARNING: If you purposely give false or misleading information, you may be fined, sent to prison, or both.