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

Office Use Only

Office of Financial Aid

2026-2027 Dependent Verification of Family Member(s)

Office: UAB, Room 252 **Phone:** 817-272-3561 **Fax:** 817-272-3555
Mail: PO Box 19199, Arlington, TX 76019 **Email:** faorecords@uta.edu
PLEASE EMAIL DOCUMENTATION FROM YOUR UTA EMAIL

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.