REQUEST FOR CSN GRANT-IN-AID FOR CLASSIFIED EMPLOYEE DEPENDENTS

☐ Dependent of Classified Employee* ☐ Spouse*
☐ Domestic Partner* ☐ Dependent of Deceased Classified Employee*

Student Name_____ Institution Attending: CSN
Student ID #_____ Year_____ Semester: Fall / Spring
Employee Name _____ Employee ID #:_____

Class Title	Course #	# of credits	Retake
			☐
			☐
			☐

☐ * I attest that the above-named dependent student meets the following Board of Regents' definition of "financially dependent child" (Title 4, Chapter 3, Section 11) of a classified staff member or his/her domestic partner who is not financially independent, is claimed as an exemption for federal income tax purposes under the U.S. Internal Revenue Code, and has not attained the age of 24.

- Dependent child of domestic partner
- Natural, adopted, stepson, or stepdaughter;
- Prior to the official start date of the semester has **not** attained the age of 24. **Age:_____Date of birth: _____**
- If over the age of 24, has served on active duty in the United States Armed Forces, date proof is attached; and
- Receives at least 50% of his or her financial support from me and/or my spouse or domestic partner.

☐ I attest that the above-named student is my spouse or domestic partner

I understand that:

1. The value of this fee waiver for a spouse or domestic partner may represent taxable income to me and, as such, will be included on my Form W-2:
2. No deductions for federal income tax will occur as a result of this fee waiver, but I may make adjustments to federal income tax withholding by completing and submitting a new Form W-4 to the Office of Human Resources;
3. If I am subject to federal withholding and/or Medicare tax, the deduction(s) will be withheld based on the value of this fee waiver (subject to maximum coverage limitations).

CSN Grant In Aid may be awarded for courses being repeated pursuant to the Course Repeat policy found in the CSN Course Catalog, unless otherwise limited by the applicable course description or a limited entry program.

I declare, under penalty of perjury under the law of the State of Nevada, that the foregoing is true and correct; that I have read all the qualifications above, as well as the excerpts that are attached to this form; and that I am entitled to request CSN Grant-in-aid for the above shown applicant(s). I understand that false representations in this certification may subject me to civil liability, disciplinary action up to and including termination, and referral to the Nevada Attorney General for criminal investigation. I also understand and agree that CSN may request proof of dependent eligibility at any time.

Employee signature	**Date**

HUMAN RESOURCES USE ONLY

	Credits	Employee	Waived	Total
U	_____	_____	_____	_____
G	_____	_____	_____	_____

Reviewed & Approved By: _____ _____
Human Resources Representative Date

Total Waiver Amount: _____

Rev. 04/2019