Benedectine University
Special Circumstance Appeal
Medical Expenses
2015 - 2016

Student Last Name: ___________________ First Name: ___________________ Student ID: ___________________

Based on the Special Circumstance Appeal Letter you submitted to our office, we are re-evaluating your need for financial aid based on out of pocket medical expenses.

Both sections I and II of this form must be completed in full. Submit all documentation together. Your appeal will be reviewed when all sections and required documentation have been completed.

Section I: Request Reason

Review the options below and select the one that pertains to the reasons you indicated in your appeal. Below each option is a list of items that need to be completed and submitted with this form.

Dependent Student

1. □ My parent(s) paid medical, dental or optical expenses in 2014 that exceeded 7.5% of the total household income earned in 2014.
   • Submit:
     □ A copy of Schedule A – if a 1040 Federal Income Tax Return was filed in 2014 and deductions were itemized
     OR
     □ A statement from each medical provider documenting the amount NOT reimbursed by insurance that was paid “out of pocket” between January 1, 2014 and December, 31 2014

2. □ My parent(s) will have medical, dental or optical expenses during the 2015-2016 school year that will not be reimbursed by insurance.
   • Submit:
     □ Documentation from the health care provider explaining the medical condition, the treatment required and cost associated with the treatment. Include a signed statement listing the out of pocket expenses associated with the treatments.

Independent Student

1. □ My spouse or I paid medical, dental or optical expenses in 2014 that exceeded 7.5% of the total household income earned in 2014.
   • Submit:
     □ A copy of Schedule A – if a 1040 Federal Income Tax Return was filed in 2014 and deductions were itemized
     OR
     □ A statement from each medical provider documenting the amount NOT reimbursed by insurance that was paid “out of pocket” between January 1, 2014 and December, 31 2014

2. □ My spouse or I will have medical, dental or optical expenses during the 2015-2016 school year that will not be reimbursed by insurance.
   • Submit:
     □ Documentation from the health care provider explaining the medical condition, the treatment required and cost associated with the treatment. Include a signed statement listing the out of pocket expenses associated with the treatments.
Section II: 2015 Income from Earnings and Benefits

This section estimates the income that will be earned by the household members through employment in 2014 as well as any other income sources. Estimate the amounts you expect to receive between January 1, 2015 and December 31, 2015. Do not leave any sections in the table below blank, if a field does not pertain to you use ‘n/a’ to indicate that.

<table>
<thead>
<tr>
<th>Student (and spouse if applicable)</th>
<th>Benefit/Income</th>
<th>Parent(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Expected in 2015</td>
<td>Employment: (list employers)</td>
<td>Amount Expected in 2015</td>
</tr>
<tr>
<td>$ ___________</td>
<td>• ___________________________</td>
<td>$ ___________</td>
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<td>$ ___________</td>
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<td>$ ___________</td>
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<tr>
<td>$</td>
<td>Pensions/Annuities</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Unemployment Compensation</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Social Security Benefits</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Child Support/Alimony</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Retirement or Disability Benefits</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Aid To Aged, Blind and Disabled</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Aid to Families with Dependent Children (ADC/AFDC or TANF)</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Worker’s Compensation</td>
<td>$</td>
</tr>
<tr>
<td>$</td>
<td>Veteran’s Benefits (non-educational)</td>
<td>$</td>
</tr>
<tr>
<td>$ ___________</td>
<td>Others:</td>
<td>$ ___________</td>
</tr>
<tr>
<td>$ ___________</td>
<td>• ___________________________</td>
<td>$ ___________</td>
</tr>
</tbody>
</table>

$______________ 2015 Total Expected Earnings/Benefits  $______________

All of the information on this form is true and complete to the best of my knowledge. I agree to provide verification of the information I have given on this form. I also realize that if I do not provide verification, I may not be re-evaluated or receive aid.

_____________________________________________________________________________________________________________________

___________________________________________  
Student’s Signature  
Date

____________________________________________  
Father’s Signature  
Date

____________________________________________  
Mother’s Signature  
Date