1718 XMD18

E

Student ID # Last Name First Name

2017-2018 REQUEST FOR PROFESSIONAL JUDGMENT
EXCESSIVE MEDICAL/DENTAL EXPENSES PAID IN 2015, 2016, 2017 or 2018

The deadline for appeals for students enrolled fall semester only is November 1, 2017.
The deadline for students enrolled spring semester only or for both fall and spring semesters is April 1, 2018.

Your request for special consideration will be considered ONLY if all necessary information is complete AND requested documentation is attached.

Please be advised that this office will exercise professional judgment only for medical/dental expenses that exceed 11% of your total income.

PLEASE CIRCLE THE YEAR FOR WHICH YOU ARE PROVIDING INFORMATION: (You may use only ONE year.)

2015 2016 2017 2018

OPTION 1: YOUR FAMILY FILED SCHEDULE "A" WITH THEIR 2015 or 2016 U.S. INCOME TAXES.

Because it has been indicated that your family paid a high amount of medical /dental expenses in 2015 or 2016, please submit a copy of Schedule A filed with the 2015 or 2016 U.S. Income Tax Return and complete the following:

The total medical/dental expenses paid in 2015 or 2016, not reimbursed by insurance were $_____

Student's Signature:_____Date:_____

Spouse/Father's/Stepfather's Signature:_____ Date:_____

Mother's/Stepmother's Signature:_____Date:_____

OPTION 2: NO SCHEDULE A WAS FILED or EXCESSIVE MEDICAL/DENTAL WAS IN 2015, 2016, 2017 OR 2018.

If schedule A was not filed, please complete the following and ATTACH COPIES OF CANCELED CHECKS OR PAID RECEIPTS FOR EACH ITEM LISTED.

An Explanation of Benefits Is NOT acceptable.

The medical/dental expenses listed below were paid by this household in 2015, 2016, 2017 or 2018 and were not reimbursed by insurance. I have not included health insurance premiums deducted from my payroll check prior to taxes. The total medical/dental expenses paid in 2015, 2016, 2017 or 2018 not reimbursed by insurance were: $_____.

Student's Signature:_____Date:_____

Spouse/Father's/Stepfather's Signature:_____Date:_____

Mother's/Stepmother's Signature:_____Date:_____

EASTERN ILLINOIS UNIVERSITY, OFFICE OF FINANCIAL AID, 600 LINCOLN AVENUE, CHARLESTON, IL 61920
TELEPHONE 217-581-6405 FAX 217-581-6422 EMAIL finaid@eiu.edu

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paid to:	amount	paid to:	amount

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Office Use ONLY

IPA _____ **MED EXP** _____

X 11%_____ **-11% IPA** _____

Adjustment _____

EFC changed from _____ **to** _____

PJ Decision:_____

_____

_____

_____

FAA Signature:_____ **Date:**_____

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