MEDICAL EXPENSES

Name: _____ Student ID Number: _____

Instructions

Complete the following worksheet and provide documentation of medical expenses you paid or expect to pay in one tax year, such as billing statements documenting payments, receipts or account summaries from your health care providers. Please contact our office for help with completing this form or with any questions you may have about your personal circumstances.

For dependent students, report medical expenses paid by the parent (s) whose income is reported on the FAFSA. For independent students, report medical expenses paid by you and/or your spouse.

Electronic and typed signatures are not acceptable. Please submit your form by mail or fax.

Medical Expenses Paid in 20_____ (year):

Please do not combine expenses from multiple years.

Date Service Received	Name of Medical Provider[1]	Total Cost of Service Received[2]	Amount Not Covered by Insurance	Amount Paid or To Be Paid	Date You Paid	Support Documents Attached
TOTAL this page:		$ 0.00	$ 0.00	$ 0.00		

By signing this worksheet, each person certifies that all the information reported on this form is complete and correct.

Student's Signature: _____ Date: _____

Parent/Spouse Signature: _____ Date: _____
(parent signature required only if student is dependent)

[1] doctor, dentist, optometrist, hospital, pharmacy, health insurance company, etc.
[2] if cost of service received is known