2017/2018
OFFICE OF FINANCIAL AID

REQUEST FOR CONSIDERATION OF SPECIAL CIRCUMSTANCES
UNUSUAL MEDICAL AND DENTAL EXPENSES

Student:_____ SJC ID/SSN:_____

Recommended Documentation:

- 2015 Federal income tax returns

  Including Schedule A Itemized Deductions

  AND

- 2015 + 2016 summary of medical and dental payments (unreimbursed portions only)

I (we) request consideration of special circumstance in determining my (our) family contribution as calculated by the federal financial aid methodology. I (we) certify that the information provided is true and complete to the best of my (our) knowledge.

_____ _____

Parent 1 **Parent 2**

_____ _____

Student **Spouse**

Return the completed worksheet to the campus you attend:
St. Joseph's College Attn: Office of Financial Aid

Long Island Campus
155 West Roe Boulevard
Patchogue, NY 11772
FAX: 631-650-2525
PHONE: 631-687-2600

Brooklyn Campus
245 Clinton Avenue
Brooklyn, NY 11205
FAX: 718-636-6827
PHONE: 718-940-5700

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Please itemize your medical and dental payments that have not been reimbursed from your insurance provider. If additional space is needed, please attach additional pages.

AMOUNT PAID	TO WHOM	SERVICE PROVIDED

I (we) certify that the information provided is true and complete to the best of my knowledge.

_____ _____

Student **Parent or Legal Guardian**

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