



2008-2009 Income Adjustment Form

Deadline to submit: Fall 2008 – November 15, 2008

Spring 2009 – April 15, 2009

Student Name: _____

SS#: _____

If you believe there are extenuating circumstances that would affect your eligibility for financial aid, you may request that we review your circumstances. Please be advised that you cannot make this request until we have received your Student Aid Report electronically. **Please complete the form and attach all required documentation.**

1. Please check the reason for your request; give the effective date of the change, and the family member to whom the change applies.

<u>REASON FOR REQUEST</u>	<u>DATE OF CHANGE</u>	<u>FAMILY MEMBER AFFECTED (e.g., self, spouse, parent)</u>
<input type="checkbox"/> Unemployment or change in employment* <ul style="list-style-type: none"> ▪ Provide documentation from former employer (on letterhead) stating last date of employment or change in employment. or proof of unemployment benefits received. ▪ 2007 Tax Return(s) and verification form must be submitted 	____/____/____	_____
<input type="checkbox"/> Divorce/Separation** <ul style="list-style-type: none"> ▪ Provide legal documentation supporting divorce (divorce decree) or legal separation. 	____/____/____	_____
<input type="checkbox"/> Death of Spouse or Parent <ul style="list-style-type: none"> ▪ Provide supporting documentation, i.e., copy of death certificate, obituary, funeral program. 	____/____/____	_____
<input type="checkbox"/> Disability of Spouse or Parent <ul style="list-style-type: none"> ▪ Provide medical documentation supporting disability claim. 	____/____/____	_____
<input type="checkbox"/> One Time Income <ul style="list-style-type: none"> ▪ This includes, but is not limited to inheritance, moving expense allowance, back year Social Security pay, IRA or pension distribution.* Provide proof of how income was spent/invested. 	____/____/____	_____
<input type="checkbox"/> Unusual Medical/ Dental expenses paid out of pocket <ul style="list-style-type: none"> ▪ Provide proof of medical expenses such as bill or receipt showing payment. 	____/____/____	_____
<input type="checkbox"/> Child care expenses paid out of pocket <ul style="list-style-type: none"> ▪ Attach signed verification of child care form. 	# of children _____	_____

2. If the reduction in income is due to the loss of employment, death or disability* or divorce/separation** of a family member, complete the appropriate column for the family member affected:

<u>Anticipated Income for January 1, 2008 through December 31, 2008</u>	<u>Student</u>	<u>Spouse</u>	<u>Parent(s)</u>
Wages, salaries, tips	\$ _____	\$ _____	\$ _____
Unemployment Benefits	\$ _____	\$ _____	\$ _____
Severance Pay	\$ _____	\$ _____	\$ _____
Cash Assistance from family/friends	\$ _____	\$ _____	\$ _____
Welfare Benefits (include TANF, AFDC, ADC)	\$ _____	\$ _____	\$ _____
Social Security Benefits	\$ _____	\$ _____	\$ _____
Child Support	\$ _____	\$ _____	\$ _____
Total Anticipated Income	\$ _____	\$ _____	\$ _____

*If the loss of income is due to the death of your spouse or parent, give only information about yourself or (if applicable) your surviving parent.

** If the loss of income is due to divorce or separation, give only information about yourself or (if applicable) your custodial parent.

Student Signature _____

Date: _____

Parent Signature _____

Date: _____