MEDICAL EXPENSE FORM 2018-2019 Academic Year

Please check one of the following  □ Continuing Student  □ New Student

__________________________________________________________ Royal ID #

Applicant's Name (please print)  

The purpose of this form is to report extraordinary medical expenses paid in calendar year 2017 for family members. Complete the worksheet below to determine if this form should be submitted.

Total amount of unreimbursed medical, dental and vision care expenses actually paid in 2017. Include paid insurance premiums. Do not include amounts covered by insurance, company medical reimbursement account (flexible spending account), or self-employed health deductions.

1. $________________

Adjusted Gross Income reported on 2017 Federal Tax Return 2. $________________

Multiply line 2 by .10 and enter answer on line 3 3. $________________

Subtract line 3 from line 1. If line 4 is less than zero, stop. 4. $________________

You are not eligible to submit this form.

If line 4 is greater than zero, University of Scranton requires you to attach a copy of your 1040 Schedule A. If you do not submit requested documents for 2017, University of Scranton will be unable to give further consideration to your request.

By signing, I attest that the above information is accurate. Furthermore I (we) understand the above data will be used to determine eligibility for federal and University of Scranton financial assistance and is subject to verification by The University of Scranton.

Applicant’s Signature_________________________ Date___________

Spouse’s Signature (if married)_________________________ Date___________

Father’s Signature_______________________________ Date___________

Mother’s Signature_______________________________ Date___________

Complete this form only if it applies to you. Return to:
The University of Scranton
Financial Aid Office
Scranton, PA 18510
Fax: 570-941-4370
Phone: 1-888-SCRANTON