MEDICAL EXPENSE FORM 2021-2022 Academic Year

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

Applicant's Name (please print) ____________________________ Royal ID # __________

The purpose of this form is to report extraordinary medical expenses paid in calendar year 2020 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 2020**. 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 2020 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.

You are not eligible to submit this form.

4. $ ______________

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 2020, 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
800 Linden Street
Scranton, PA 18510
Fax: 570-941-4370
DO NOT EMAIL