

Name (printed)

University ID Number

E-mail

Phone

**Please document expenses in excess of the Cost of Attendance**

Fall Semester

Spring Semester

Summer Semester

\$ _____	<b>Course Fees:</b> <i>I have course fees on my university bill.</i>												
\$ _____	<b>Commuting expenses:</b> <i>I have commuting expenses required to complete my DVM.</i> <b>Not considered:</b> commuting expenses for reason other than traveling to and from home to class, purchase of a vehicle, car payments, care insurance, license, registration, maintenance, and repairs <ul style="list-style-type: none"> <li>• Commuters: provide starting and ending address for travel directly related to education (ie: home to ISU)</li> </ul>												
\$ _____	<b>Health or Dental insurance:</b> <i>I have Student &amp; Scholars Health and/or Dental insurance on my university bill.</i> The Office of Student Financial Aid will adjust for health and dental insurance that exceeds \$500/semester.												
\$ _____	<b>Out of pocket medical expenses:</b> <i>I paid for medical bills not covered by health insurance out of pocket.</i> <b>Documentation:</b> You will provide proof of payment of medical expenses paid out of pocket during the semester the cost of attendance is requested. Do not include your health insurance Explanation of Benefits.  <i>Out of pocket medical expenses must be assessed and paid out of pocket by the student during the semester the cost of attendance adjustment is requested. Out of pocket expenses not on the university bill and that exceed \$500/semester are not guaranteed for approval and may be reviewed by a committee to determine if the out of pocket medical expenses can be covered by Federal Student Aid. Federal Student Aid and the Office of Student Financial Aid are not responsible for covering out of pocket medical expenses not paid by insurance, and the student accepts that they are the responsible payer of those expenses if the cost of attendance adjustment request is not approved.</i>												
<b>Daycare:</b> <i>This adjustment request is considered for one semester only and must be completed each semester that you incur daycare expenses for your dependent children.</i>													
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">Name of Child</th> <th style="width:10%;">Age</th> <th style="width:40%;">Name of Daycare Provider</th> <th style="width:10%;">Out-of-Pocket Weekly Daycare Expenses</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: center;">\$</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: center;">\$</td> </tr> </tbody> </table>		Name of Child	Age	Name of Daycare Provider	Out-of-Pocket Weekly Daycare Expenses				\$				\$
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<i>If your spouse is also a student and receiving federal financial aid, please list his/her name and the college he/she is attending. If both you and your spouse are receiving federal financial aid, then only one may receive this adjustment.</i>													
Spouse's Name (printed)	Spouse's College												

**You must submit the cost of attendance adjustment form by finals week of the semester the adjustment is requested.**

*By signing this form, I certify that the information provided within this request is accurate and that your cost of attendance adjustment approval is not guaranteed. Your adjustment is not approved, you acknowledge that you are the responsible payer of adjustments not approved. I acknowledge that I will be liable for repayment of any financial assistance received if the information that I am providing is inaccurate.*

Student Signature (computer-generated signature will not be accepted)

Date

<b>FOR OFFICE USE ONLY</b>	
Adjustment made: \$ _____	Semester _____ Date _____ Denied _____ Advisor _____
Comment: _____	
_____	

