HELENA COLLEGE
University of Montana

MEDICAL EXPENSES REQUEST FOR PROFESSIONAL JUDGEMENT

Student Name: _____ ID: 770-_____

Permanent Street Address: _____

City/State/Zip: _____

Permanent Phone #: (_____) _____-_____

Academic Year: _____-_____

Type of Professional Judgment:

____ Extremely High Medical Expenses (Over 11% of gross income.)

Your request will need to include the following:

- **Medical Expense Form (see attached)**
- **Last 2 years of IRS Federal Tax Transcripts & W2's for student (spouse or parent(s) if applicable)**
- **Most recent pay stubs for student (spouse or parent(s) if applicable)**
- **Completed Household Verification Worksheet**
- **Completed Untaxed Income Form**
- **Completed Asset Information Form**
- **Signed & dated DETAILED (dates and amounts – a financial timeline) statement explaining current situation and the reason for requesting a Professional Judgment**

I am requesting that the Financial Aid Director at Helena College University of Montana consider my circumstances to determine if I may be eligible for a professional judgment according to the Department of Education Federal Regulations. This determination may allow my financial aid eligibility to change at the Helena College University of Montana only. I agree to provide any documentation requested by the Financial Aid Director if it can be obtained. I understand that this decision is made by the Financial Aid Director based upon documentation I supply and that any professional judgment decisions are final.

Student Signature _____ Date _____

This form and any required/requested documentation must be given to the Helena College Financial Aid Office prior to any professional judgment being granted.

FOR QUESTIONS CALL: FINANCIAL AID OFFICE, Helena College, 1115 N. Roberts Street, Helena, MT 59601
406-447-6916, www.helenacollege.edu
RETURN DOCUMENTATION TO: FINANCIAL AID OFFICE, Helena College, 1115 N. Roberts Street, Helena, MT 59601, or fax to: 406-447-6397.

HELENA COLLEGE
University of Montana

Unusual Medical and Dental Expenses **2018-2019 YEAR**

Student's Name: _____ Student ID No: _____

ATTACH ALL RECEIPTS, INSURANCE STATEMENTS, BILLS AND/OR OTHER DOCUMENTS PERTINENT TO THE INFORMATION BELOW.

1. Enter the amount paid for medical/dental insurance in 2016. $_____
   (do not include employer contribution)
2. Enter the amount of your 2016 medical/dental expenses not paid by insurance. $_____

3. Explain if your unreimbursed medical/dental expenses will be lower, the same, or higher from 1/18-12/18, and the reasons for the difference.

4. List the sources from which you will finance these expenses.

By signing this worksheet, I certify that all of the information reported to qualify for Federal Student Aid is complete and correct. **Dependent students must include parent(s') signature(s)**.

_____ _____
Student Signature Date Spouse Signature Date

_____ _____
Mother's Signature Date Father's Signature Date