



## MEDICAL EXPENSES REQUEST FOR PROFESSIONAL JUDGEMENT

Student Name: \_\_\_\_\_ ID: 770-\_\_\_\_\_

Permanent Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Permanent Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Academic Year: \_\_\_\_\_ - \_\_\_\_\_

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

### Your request will need to include the following:

- **Medical Expense Form (see attached)**
- **Household Verification Form**
- **2022 IRS Tax Transcripts if unable to have data automatically uploaded into FAFSA for student (spouse or parent(s) if applicable)**
- **Most recent pay stubs for student (spouse or parent(s) if applicable)**
- **Copies of bills or other documentation to support your circumstance**
- **Signed & dated DETAILED (dates and amounts – a financial timeline) statement explaining current situation and the reason for requesting a Professional Judgment**

I am requesting 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](http://www.helenacollege.edu)

RETURN DOCUMENTATION TO: FINANCIAL AID OFFICE, Helena College, 1115 N. Roberts Street, Helena, MT 59601, or  
fax to: 406-447-6397.



## Unusual Medical and Dental Expenses

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 2022.     \$ \_\_\_\_\_  
(do not include employer contribution)
2. Enter the amount of your 2022 medical/dental expenses not  
paid by insurance.     \$ \_\_\_\_\_
3. Explain if your unreimbursed medical/dental expenses will be lower, the same,  
or higher from 1/24-12/24, 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