



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)**
- **Family Size Verification Form**
- **2024 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**

**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 2023. \$ _____
(do not include employer contribution)
2. Enter the amount of your 2023 medical/dental expenses not
 - a. paid by insurance. \$ _____
3. Explain if your unreimbursed medical/dental expenses will be lower, the same,
 - a. or higher from 1/25-12/25, 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