

2011-2012 Parent Request for Medical/Dental/Nursing Home Expense Adjustment

****This form must be submitted by May 1, 2012 to be considered for the 2011-2012 academic year****

THE UNIVERSITY OF IOWA
Office of Student Financial Aid
208 Calvin Hall
Iowa City, Iowa 52242-1315

(319) 335-1450
(800) 553-4692
E-Mail: financial-aid@uiowa.edu

Student's Name (please print)

UI ID Number

If your parents have incurred medical/dental/nursing home expenses that you would like us to review for an increase in your cost of attendance, follow the instructions below. **If your expenses are for routine medical/dental check-ups, elective procedures, or cosmetic surgery, do not complete this form.** We will not consider routine expenses because they have already been included in your cost of attendance.

We can only consider medical/dental/nursing home expenses that were paid in 2010. Expenses paid by pre-tax income through a health care spending account cannot be considered.

Please attach a copy of Schedule A from your parents' 2010 federal income tax return that identifies the medical/dental/nursing home expenses itemized in 2010. If expenses were not itemized on their tax return, please see the back of this form for instructions.

(OVER)

Student Name: _____

Student UI ID #: _____

Complete only if medical/dental/nursing home expenses were not itemized on Schedule A of your parents' tax return. If submitting multiple expenses, you must itemize them on this form. **For each item**, include the type of expense, the date, the amount incurred/paid, and to whom. Attach copies of the Explanation of Benefits, paid receipts, itemized invoices, cumulative billing statements, or other documents indicating the date of payment for each expense paid from January 1, 2010 through December 31, 2010. Copies of cancelled checks cannot be accepted. You may be able to find the Explanation of Benefits, history of service, claims, prescriptions, etc., on your insurance provider's website. Attach additional sheets, if necessary.

Name of person receiving treatment: _____ Relationship to student: _____

Name of Provider	Date Paid in 2010	Type of Service	Amount Paid by You (not reimbursed by insurance)

Name of person receiving treatment: _____ Relationship to student: _____

Name of Provider	Date Paid in 2010	Type of Service	Amount Paid by You (not reimbursed by insurance)

Name of person receiving treatment: _____ Relationship to student: _____

Name of Provider	Date Paid in 2010	Type of Service	Amount Paid by You (not reimbursed by insurance)