Florida Agricultural and Mechanical University
TALLAHASSEE, FLORIDA 32307-3100

Excellence With Caring

DIVISION OF STUDENT AFFAIRS
OFFICE OF FINANCIAL AID

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2018-2019 Special Circumstance Review Application

All applicants are required to complete this section. (The application will be returned if all applicable pages are not completed and submitted.)

_____
Student ID #

_____ _____ _____
Student's Last Name | Student's First Name | Student's Middle Initial

_____ _____ _____ _____
Local Street Address | City | State | Zip

( ) _____ ( ) _____ ( ) _____
Home Telephone Number | Work Telephone Number | Other Telephone Number

This application should be used **AFTER** the 2018-2019 Free Application for Federal Student Aid (FAFSA) has been submitted. Complete this form ONLY if there has been recent unusual or extenuating circumstances, which have caused a significant decrease in your 2016 taxable or non-taxable income.

Each request for a special circumstance review is evaluated on an individual basis. In order to have your award re-evaluated; your initial award must be processed first. The number of special circumstance requests by this office may possibly cause a delay in reviewing your application. The student will be notified by mail of the decision.

Circumstances which might be considered unusual or extenuating may include (but not limited to) the following:

- ☐ A. Income Reduction
- ☐ B. Non-elective Medical/Dental expenses (not covered by insurance)
- ☐ C. Dependent Care expenses for family members with disabilities or handicapped
- ☐ D. Child Care expenses for Independent students only
- ☐ E. Unusual debts
- ☐ F. Professional Licensure

PLEASE NOTE:

1) **Submitting a special circumstance review application does not guarantee additional funding.**
2) **Current or future financial aid could be adjusted/revised if the documentation does not support the claim.**
3) **The Office of Financial Aid will review accordingly and advise.**

Please select **ONLY ONE** of the appropriate boxes.

A. *INCOME REDUCTION*

Will your income and/or your parent(s)/spouse's income be less in the 2016 calendar year than reported on your FAFSA? Select one option.

□ 1. **UNEMPLOYMENT** Effective Date _____ New Date of Employment _____

Required Documents:
-Employment Verification Form (supplied with packet)
-Certification of total 2016 unemployment benefits eligibility
-2018 earnings up to the last date of employment (2016, 2017, 2018)
-2017 Tax Return Transcript

□ 2. **CHANGE IN EMPLOYMENT** Effective date _____

Required Documents:
-Employment Verification Form (supplied with packet)
-First and/or last date of employment
-2017/2018 earnings up to the last date of employment
-2017 Tax Return Transcript

□ 3. **RETIREMENT** Effective date _____ (Circle year and include effective date information)

Required Documents:
-Employment Verification Form (supplied with packet)
-First and/or last date of employment
-2016/2017 earnings up to the last date of employment
-2016/2017 Tax Return Transcript
-if military discharge, copy DD214
-retirement statement for 2016/2017
-Certification of unemployment benefits (if applicable)

□ 4. **DIVORCE / SEPARATION** Effective date _____(Circle year and include effective date information)

Required Documents:
-Divorce -Copy of divorce decree
-Separation -Copy of legal separation or
- A notarized statement verifying separation
-Rent and/or utility receipts for both parents
-2016/2017 Tax Return Transcript (both parties)
-2016/2017 W-2s (both parties)

□ 5. **DEATH** Effective date _____

Required Documents: -Obituary -Copy of death decree

□ 6. **DISABILITY** Effective date _____

Required Documents:
-A letter from the doctor stating the nature and date of disability
-Copy of expected social security benefits for 2016/2017

□ 7. **LOSS OF BENEFITS AND/OR UNTAXED INCOME** Effective date _____

Child Support □ Alimony □ Workman's Comp □ Social Security □ Disability □ Other □

Required Document: Letter certifying appropriate loss on verifying letterhead

B. NON ELECTIVE MEDICAL/DENTAL EXPENSES (NOT COVERED BY INSURANCE)

1. How much did you/your parent(s) /spouse pay for medical/dental insurance in 2016? (Do not include employer's contribution.) $ _____

2. Amount paid for 2016 medical/dental expenses NOT paid by insurance. $_____

3. Amount expected to pay for 2016 for medical/dental expenses NOT paid by insurance. $ _____

Unusual Medical/Dental Expenses

Medical/Dental expenses up to 11% of the family's income are already taken into account by the federal need analysis formula when determining financial aid eligibility. Therefore, only the portion of expenses which exceed 11% will be considered an unusual circumstance.

Required Documentation: -2016 Tax Return Transcript and all attachments **AND**
-Paid receipts of medical and dental payments NOT covered by insurance
(HIGHLIGHT YOUR PORTION OF THE PAYMENT)

C. DEPENDENT CARE EXPENSES FOR FAMILY MEMBERS WITH DISABILITIES AND/OR HANDICAPPED

1. Do you pay for elementary or secondary education expenses for a disabled or handicapped family member?
Yes □ No □

List family member(s) and the amount of expenses for each by completing the grid below:

Family Member's Name	Age	Relationship	Elementary Ed Expense	Secondary Ed Expense	Total 2016 Expenses

2. Do you have dependent care expenses for elderly or disabled family member(s)? Yes □ No □

Family Member's Name	Age	Relationship	Total Care Expenses 2016

Required Documentation: -2016 Tax Return Transcript and all attachments
-Paid receipts for payments made in 2016
-Letter from caregiver stating amount of payment for the 2016 year

D. CHILDCARE EXPENSES (INDEPENDENT STUDENTS ONLY)

List your child(ren) enrolled in childcare and the amount paid below

Family Member's Name	Age	Total 2014 Expenses

Required Documentation: -2016 Tax Return Transcript
-Receipts for payments made in 2016
-Letter from daycare provider stating total fees paid by student in 2016

E. UNUSUAL DEBTS

NOTE: Debts like car, mortgage, credit cards and school loans are NOT unusual debts.

1. Did you have unusually high debts or loans due to unemployment, failed business, or emergency medical expenses during 2016 or 2017 for which you are currently making monthly payments? □ Yes □ No

   If yes, provide the following information: (NOTE: If additional debts have been incurred, write the information on an additional sheet of paper and attach to this application.)

   a. Type or cause of debt: _____

   b. Owed by whom? _____

   c. Amount of original debt: $ _____

   d. Date incurred (month/year): _____

   e. Balance owed on debt: $ _____

   f. Date payments began (month/year): _____

   g. Monthly payment: $ _____

   h. Holder of debt: _____

   i. Date payments end (month/year): _____

   j. Were these expenses higher in 2017 or will they be higher in 2018? Explain why:
   _____
   _____
   _____

   k. From what resources will you finance these expenses? _____
   _____
   _____

Required Documentation:
- -Contract
- -Lien
- -Billing or payment summary from person, company, or agency to which debt is owed

F. PROFESSIONAL LICENSURE

Students in a field of study which requires professional licensure (i.e. Law or Accounting) for practice in the profession may submit proof of payment for licensure examination for an adjustment in Cost of Attendance. Only the examination costs may be included; no preparatory costs will be considered.

ESTIMATED INCOME FOR 2018 CALENDAR YEAR
(Please complete applicable sections)

If you (the student) are divorced or separated, include only YOUR income information. If your parents are divorced or separated, include only your custodial parent's income information. If your custodial parent has remarried, you must include their spouse's income information. If the loss of income is due to the death of your (the student) spouse/parent, include only YOUR income information or the surviving parent's income information.

NOTE: Write in zero (0) if an item does not apply (1/1/2018 – 12/31/2018)

	Father	Mother	Student	Spouse
Taxable: Wages, Salaries, and Tips				
State Unemployment Benefits				
Pension				
Alimony				
Other (please specify)				
Non-Taxable: Social Security Benefits				
AFDC				
Child Support Received				
Other Untaxed Income/ Benefits				
TOTAL ANTICIPATED INCOME				
Cash & Savings				

HOUSEHOLD SIZE AND NUMBER IN POST-SECONDARY SCHOOL

This section MUST be completed if your household size or number of family members enrolled in post-secondary education has changed since you completed the original FAFSA.

Write the number of people that your parents (or you and your spouse) will support between July 1, 2018 and June 30, 2019. Include yourself (the student) in this figure. Write in the number of people from the household who will be attending post-secondary school between July 1, 2018 and June 30, 2019. Include yourself (the student) but only include others if they are enrolled on at least a half-time basis in a degree or certificate program.

Total Number of Family Members: _____

Number in College: _____

EXPLANATION OF EXPENSES AND/OR INCOME REDUCTION

(All must complete this section)

Please explain in detail the reason(s) for your request for special consideration. Give details of your income reduction, extenuating circumstances or additional expenses. Provide an additional sheet if necessary.

CERTIFICATION STATEMENT:

** Although your Special Circumstances may be approved, it may not warrant additional aid due to availability of funds.

We certify that the information provided on this form is complete and accurate to the best of our knowledge. If additional changes occur during the 2018-2019 academic year that would alter the information provided on this Special Circumstance Form, we will immediately contact the Financial Aid Office.

Student's Signature _____ Date _____

Spouse's Signature _____ Date _____

(Step) Father's Signature _____ Date _____

(Step) Mother's Signature _____ Date _____

WARNING: If you purposely give false or misleading information on this worksheet, you may be fined, sentenced to jail, or both.

EMPLOYMENT VERIFICATION

Student's Name _____ SSN _____

Additional information is required in order to further process your request due to loss of employment in your family. Please sign below to authorize release of information and then give this form to your present or previous employer. When the employer completes this form, return it with all other forms to the address below.

If you are not presently employed, when was your last date of employment? _____

_____ _____
Employee's Name (Please Print) Relation to Student Social Security Number

_____ _____
Employee's Signature Date

EMPLOYER SECTION: TO BE COMPLETED BY EMPLOYER (CURRENT/PREVIOUS)

Company's Name: _____ Address: _____

City/State/Zip Code:_____

Name of person completing this section (Please Print): _____

Title: _____

Business Telephone: _____ Fax # _____ Date _____

Please complete lines that apply:

The individual name above is/was employed beginning: Month _____ Day _____ Year _____

_____ Terminated employment Month _____ Day _____ Year_____

_____ Number of hours worked

_____ Reason for termination _____

_____ Still employed by the company

_____ Number of hours per week

Income: Hourly Rate of Pay:_____ Gross Salary $_____ Per _____

TOTAL EARNED YEAR-TO-DATE: $ _____

Signature of person completing this section_____