2021-2022 Parent Request for Medical/Dental/Nursing Home Expense Adjustment

****This form must be submitted by May 1, 2022 to be considered for the 2021-2022 academic year****

Student Name: _____ UI ID Number: _____

You and/or your parent(s) indicated that your parent(s) paid high medical/dental/nursing home expenses in 2019. Additional documentation is required for our office to determine whether these expenses can be considered Submitting this information does not guarantee a change in financial aid.

We can only consider medical/dental/nursing home expenses that were paid in 2019. Expenses paid by pre-tax income through a health care spending account cannot be considered.

Option 1:
Provide a copy of Schedule A from your parent's 2019 federal income tax return that identifies the medical/dental/nursing home expenses itemized in 2019.

Option 2:
If expenses were not itemized on their tax return, please see the back of this form for instructions. Your parent's out-of-pocket (already paid) expenses must exceed $2000.

To determine which expenses are eligible to be considered, go to https://www.irs.gov/publications/p502

Total of your 2019 medical/dental/nursing home expenses: $_____

(Continue to next page)

Office of Student Financial Aid
2400 University Capitol Centre, Iowa City, Iowa 52242 | 319-335-1450 | Fax 319-335-3060 | financial-aid@uiowa.edu | financialaid.uiowa.edu

Student Name: ______________________________ UI ID Number: ____________________

Option 2:
Complete only if medical/dental/nursing home expenses were not itemized on Schedule A of your parent's 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 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, 2019 through December 31, 2019. Copies of cancelled checks cannot be accepted. You may be able to find the Explanation of Benefits, history of service, claim, prescriptions, etc., on your insurance provider's website. You can also contact your insurance company for this information. Attach additional sheets, if necessary. **Your expenses must exceed $2000 to submit this form.**

Name of person receiving treatment: ____________________ Relationship to student: __________

Name of Provider	Date Paid in 2019	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 2019	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 2019	Type of Service	Amount Paid by You (not reimbursed by insurance)