2022-2023 Parent Request for Medical/Dental/Nursing Home Expense Adjustment

**This form must be submitted by May 1, 2023 to be considered for the 2022-2023 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 2020. 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 2020. 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 2020 federal income tax return that identifies the medical/dental/nursing home expenses itemized in 2020.

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 2020 medical/dental/nursing home expenses: $____________________

(Continue to next page)
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, 2020 through December 31, 2020. 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. **Your expenses must exceed $2000 to submit this form.**

| Name of person receiving treatment: ____________________________ | Relationship to student: _____________ |
| Name of Provider | Date Paid in 2020 | Type of Service | Amount Paid by You (not reimbursed by insurance) |
| Name of person receiving treatment: ____________________________ | Relationship to student: _____________ |
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