

**2007-2008
EASTMAN SCHOOL OF MUSIC
FINANCIAL AID APPEAL FORM**

Eastman School of Music-Financial Aid Office
26 Gibbs St.
Rochester, NY 14604
Phone: (585) 274-1070; Fax: (585) 232-8601
Email: financialaid@esm.rochester.edu

APPEALS WILL BE REVIEWED UPON RECEIPT OF DOCUMENTATION

-Please Print in Blue or Black Ink-

Student Name _____ Student ID# _____

Street Address _____

City _____ State _____ Zip Code _____

Phone #(_____) _____ Email Address _____

Parent's Name _____ Day Phone # (_____) _____

Parent's Email Address _____

Only one parent or guardian required (if applicable)

Citizenship Status (check one)

- United States Citizen
 Alien in Permanent Residence
 International

Academic Information

Degree Program: _____
Major: _____
Expected date of completion: _____
What year of study will 2007-08 be for you? _____

The University of Rochester Eastman School of Music has an appeal process through which you may request reconsideration of your federal aid. You must be able to document a significant change in your family's financial circumstances, or be able to document special circumstances that were not considered initially, by completing this form. Federal regulations and institutional policies require that exceptions fall within certain parameters and are documented. This form is designed to assist you in providing information critical to the review of your appeal.

A Financial Aid Counselor will review your appeal. The decision will be based on the individual circumstances outlined in the completion of this form. Students will be notified, in writing, of the appeal decision. **Please note, submission of an appeal does not guarantee an adjustment to a student's award.**

**PLEASE COMPLETE ALL SECTIONS THAT
APPLY TO YOUR SITUATION AND PROVIDE ALL
DOCUMENTS REQUIRED.**

Section A: Conditions for Consideration of Additional Federal/Eastman Assistance

The questions below will assist us in understanding why your household is experiencing a decrease in financial resources. Please complete all sections that apply to your situation. Deadlines for Documentation are listed for each situation.

1. Loss/Change of job?

What family member experienced a job loss, or change in income? _____ Father/Step _____ Mother/Step

What was the effective date? _____ Self _____ Spouse

- Reason for reduction/loss: Job Change Reduced Commissions or Overtime
 Retirement Termination by Employer
 Other (please specify) _____

Attach most recent pay stub showing new/changed salary. Include last pay stub from any position terminated in 2006. Also, include documentation of unemployment benefits. Complete Section B.

2. Loss of Untaxed income/benefits? (i.e. Child support, unemployment, AFDC, etc.)

Person receiving the benefit: _____ Parent(s) _____ Student Date of Change _____

Name of benefit(s) that were affected: _____

Amount Received from January 1, 2007 to present _____

Amount Received from present to December 31, 2007 _____

Please attach documentation of changes/loss. If this is your only income change, do not complete Section B.

3. Parent's Separation/Divorce or Death of a Parent?

Complete this section only if your parents separated or divorced OR a parent died **AFTER** the 2007-2008 FAFSA was completed.

For parent' separated/divorced:

For death of a parent:

Which parent do you live with? Father Mother

Date of death: _____ (month/year)

Date of separation/divorce: _____ (month/year)

Surviving parent: Father Mother

Complete Section B and attach explanation of separation of assets, child support or alimony, if applicable.

4. Unusually High Medical/Dental Expenses?

Write in the amount paid out-of-pocket in 2007 and expected to be paid in 2007 for medical and dental expenses, including insurance premiums. Do not include amounts reimbursed by insurance.

Total Paid to Date in 2007: \$ _____ Total Expected to be Paid in 2007: \$ _____

Reason for Expenses:

- Permanently Disability Terminal Illness Other (specify) _____

Attach a detailed explanation of the reported expenses and attach documentation when available. For permanent disability or terminal illness please have a physician complete Section D. If this is your only income change, do not complete Section B.

5. Parent is Attending College?

- Parent is attending an accredited college or university at least halftime in the 2007-2008 academic year.

Attach a copy of registration form showing parent registered for 6 credit hours or more. If this is your only change, do not complete Section B.

Section B: 2007 Estimate Income/Expenses

Awards for the 2007-2008 academic year are based on the 2006 income information that was provided on your FAFSA. If your household income for 2007 will be significantly different than it was in 2006, financial aid eligibility *may* be re-evaluated on that basis. Any adjustment to your financial aid award made on this basis of the additional information *will be tentative, until all documentation of actual 2007 income has been received*. Estimates provided in the following section should be as accurate as possible in order to avoid later adjustments in your aid package. **ENTER "0" OR "N/A" WHERE APPROPRIATE. DO NOT LEAVE ANY ITEM BLANK.**

TAXABLE INCOME	Actual Amount (January 2007 to present)	Estimated Amount (Present – December 2007)	Total Amount (Add actual and estimated values)
Wages, salaries, compensation from jobs	XXXX	XXXX	XXXX
Student			
Spouse (if applicable)			
Father/Stepfather			
Mother/Stepmother			
Interest and Dividends Income			
Net income/loss from business (<i>reported on Schedule C or F</i>)			
Severance Pay			
Capital gain/loss (<i>reported on Schedule D</i>)			
Rental income/loss (<i>reported on Schedule E</i>)			
Taxable portions of Social Security			
Taxable portions of pension/annuity withdrawals			
Income from royalties, partnerships, estates, trusts			
Alimony received			
Unemployment compensation			
Other taxable income			
UNTAXED INCOME			
Social Security/ SSI benefits			
Welfare benefits, including ADC and TANF			
Child Support received			
Voluntary contributions to retirement plans (<i>i.e. 401(k), 403(b)</i>)			
Veteran's Benefits			
Housing Allowance (<i>military and clergy</i>)			
Other untaxed income			
EXPENSES		XXXX	
Child Support paid		XXXX	
Alimony paid		XXXX	
Medical and dental expenses not reimbursed by insurance (<i>including insurance premiums paid</i>) ¹		XXXX	
Private Elementary or Secondary School tuition for siblings in 2007-08 academic year. (<i>include only your out-of-pocket costs- NOT the full tuition</i>) ²	XXXX	XXXX	

¹ You must attach all itemized proof of these unreimbursed expenses. Receipts, insurance records, your doctor's records or estimates are all acceptable as proof.

² Number of Children enrolled in private school: _____ *Attach bill or statement on school letterhead*

Name of School (s): _____
 Address: _____
 Telephone #: _____

Section C: Additional Information

If the space provided above did not allow you to fully explain the circumstances please attach a supplementary letter to provide additional information describing the basis for your request. For example, include any information concerning financial assistance provided to family members in need or one-time emergency expenses. Attach additional pages and documentation as necessary.

Section D: Physician's Certification

Instructions for physician: You are being asked to complete and sign this form to certify that _____

is temporarily totally disabled has been diagnosed with a terminal illness other

You may complete this form **only** if you are a **doctor of medicine or osteopathy** legally authorized to practice. Sign the certification only if the person diagnosed is unable to work and earn money for at least 60 days in order to recover from an injury or illness. Provide all requested information (you may attach additional pages). Report dates as month-day-year.

- The disabled person became unable to work and earn money or attend school, or required continuous nursing or similar care on ____-____-____. The disabling condition or care is expected to continue until ____-____-____.
- Diagnosis of the disabled person's present medical condition (please describe the condition – do not use abbreviations or insurance codes):
- If different from the date you provided above, when did the disabled person's injury or illness begin? ____-____-____

I certify that, in my best professional judgment, the person identified is unable to work and earn money for at least 60 days because of a medically determinable impairment. I am a **doctor of medicine or osteopathy** legally authorized to practice.

Physician's Name (printed): _____ Telephone #: _____
Address: _____ City, State, Zip: _____
Physician's Signature: _____ **Date:** _____

Section E: Student Certification

By signing below, I affirm that the data contained on this form is true and complete to the best of my knowledge. Upon request, I will provide documentation to substantiate the information provided. Also, I understand that both the Eastman School of Music and the Secretary of Education have the authority to verify information reported on this application with the Internal Revenue Service and other federal agencies and reserve the right to report any false or misleading information.

Student _____ Date _____

Parent (or Spouse*) _____ Date _____

-Both the student and a parent (or spouse of student) must sign for the process to continue-

**PLEASE RETURN THE COMPLETE APPLICATION TO: ESM FINANCIAL AID OFFICE
26 GIBBS STREET, ROCHESTER, NEW YORK 14604**

FOR OFFICE USE ONLY: _____ APPROVED _____ DENIED

ADJUSTMENTS _____

SIGNATURE _____ DATE _____