State Grant and Special Programs
Phone: 1-800-692-7392 Fax: 717-720-3786
P.O. Box 8157, Harrisburg, PA 17105-8157

2017-18 MEDICAL/DENTAL EXPENSE FORM
(INDEPENDENT STUDENT)

(NOTE: Deadline for returning this form and requested documentation to PHEAA is April 1, 2018.)

_____
Print Student's Name

Student's Social Security Number
OR
Student's Account Number
2017-18

The Agency may permit reconsideration of an application if your family paid extraordinary unreimbursed medical/dental expenses during 2015. You should provide the requested information regarding family medical/dental expenses to PHEAA, P.O. Box 8157, Harrisburg, PA 17105-8157 within 30 days. No data will be accepted after April 1, 2018.

Submit a complete copy of your (and your spouse's, if married) 2015 U.S. Income Tax Return (as filed with IRS), including all supporting forms, schedules, and W-2 Forms, if such has not previously been submitted, and this form which aids in the immediate identification of your record. Each W-2 Form should contain figures in Box 1 and either Box 16 or Box 18. If you (and your spouse, if married) have an interest in a corporation and/or partnership, you also need to submit copies of the appropriate U.S. Partnership and/or Corporation Tax Return(s), including the completed balance sheet(s) and K-1 schedule(s). If your family owns and controls more than 50% of a business and has 100 or less full-time or full-time equivalent employees, please indicate such with the correspondence you are sending. If you (and your spouse, if married) itemized medical expenses on Schedule A, you should submit a copy of Schedule A. If you did not file or did not retain a copy of Schedule A, you should complete the following questions and provide documentation of the larger extraordinary expenses.

If you have any questions regarding this matter, please contact Agency staff at 1-800-692-7392 (TTY: Dial 711 for hearing impaired).

1. Indicate the amount of money which you (and your spouse, if married) PAID in 2015 for medical and dental expenses (including insurance premiums). Do not include amounts covered by insurance, your company pre-tax medical/dental reimbursement account (flexible spending account), monies paid toward establishing the company medical reimbursement account if tax-deferred, or self-employed health deductions from Form 1040 – line 29.

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2. Indicate whether your medical/dental expenses were paid from income, savings, and/or other sources and indicate the approximate amount paid from each source. Also provide an explanation for the reason your family experienced these extraordinary expenses during 2015.

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THE PENALTY FOR SUBMISSION OF FRAUDULENT INFORMATION ON THIS FORM MAY BE REPAYMENT OF TRIPLE ANY AMOUNT OF MONEY RECEIVED PLUS A FINE AND/OR IMPRISONMENT.

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Signature of Student Date Signature of Spouse (if married) Date