

MEDICAL STUDENT BUDGET APPEAL REQUEST

Expenses in Excess of Standard Cost of Attendance

Complete this form to request a budget adjustment for expenses that exceed the standard cost of attendance. (Requests must be submitted at least 15 days prior to the end of the trimester/academic year. Please allow 7-10 business days for processing. Students will be notified of status via their UND student email account.)

Student Name: _____ Student ID: _____ Class of: _____

Address: _____ City, St, Zip: _____ Phone #: _____

Household Information: Marital Status: Single Married Is spouse employed? Full-Time Part-Time No

Is spouse a student? Yes No Spouse's Name: _____ Number of Dependent Children: _____

Academic Year: 20__ - 20__ Select all terms for your request: Full Academic Year: OR Term1 Term2 Term3

Important Information

- Budget appeal requests must include **this form, letter explaining your need for a budget adjustment, and documentation of expenses** (i.e. copy of lease, utility bill, medical bill, day care receipt, etc.).
- You may be required to meet with a financial aid advisor during the appeal process.
- Expenses must be incurred during the period of enrollment in which you are requesting a budget adjustment, and will be reviewed on a case-by-cases basis.
- Submission of a budget appeal request does not guarantee additional funding.

Expenses*

Expense Type	Monthly Expense	One-Time Expense	Detailed Documentation Submitted
Rent/Mortgage, Utilities, Insur., etc.			
Food/Groceries			
Gas/Car Maint., Auto Insur, etc.			
Medical/Dental/Optical & Insur.			
Toiletries/Personal			
Books/Supplies/Computer			
Child/Adult Care			
Other			

**Any expenses without documentation will not be considered.*

What is the total amount of additional funding you are requesting? _____

Warning: If you purposely give false or misleading information on this form to help establish eligibility for Federal Student Aid, you may be subject to a \$20,000 fine, a prison sentence, or both.

I affirm the information provided on this form and any documentation submitted is a true and accurate reflection of my expenses, and that these expenses are directly related to my medical school education.

Student's Signature: _____

Date: _____



MEDICAL STUDENT BUDGET APPEAL SUPPLEMENT

Commuting, Child/Adult Care Expenses and/or Computer Purchase

Complete the applicable sections below if you are requesting a budget adjustment for expenses related to: commuting to/from school, the purchase of a computer or tablet, and/or child/adult care.

Computer/Tablet Expenses

Are you requesting a budget adjustment for a computer or tablet? _____

Have you previously requested a budget adjustment for a computer purchase? Yes No

Have you previously requested a budget adjustment for a tablet purchase? Yes No

Have you verified this computer/tablet is compatible with the technology requirements of the M.D. program? Yes No

Commuting Expenses

Do you commute more than 40 miles (round trip) daily to attend class or clinical requirements at UND SMHS? Yes No

Commute From	Commute To	Miles/Day (Roundtrip)	Days/Week	Weeks/Semester	Semester

You must include reason for commuting in your letter explaining need for a budget adjustment.

Child or Adult Care Expenses

Are you (or will you be) receiving childcare assistance from any source? Yes No

If so, which source? _____ What is the monthly amount you expect to receive? _____

Dependent's Name	Age	Avg. Hours/Day	Hourly Day Care Rate	Avg. Monthly Expense

Name of Child/Adult Care Provider: _____ Phone: _____

Address of Provider: _____

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I affirm the information provided on this form and any documentation submitted is a true and accurate reflection of my expenses, and that these expenses are directly related to my medical school education.

Student's Signature: _____ Date: _____