

**2011-2012
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

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)

Academic Information

Degree Program: _____ Major: _____

Expected Date of Completion: _____

The 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 unforeseen situations that were not considered initially, by completing this form. Federal regulations and institutional policies require that exceptions are documented and fall within certain parameters. This form is designed to assist you in providing information critical to the review of your appeal. Students and their family will be notified of the appeal decision in writing.

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.

1. Loss/Change of job?

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

Date of change? _____ _____ Self _____ Spouse

Reason for reduction/loss: Job Change 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 2010
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 was/were affected: _____

Amount Received from January 1, 2011 to present? _____

Amount Received from present to December 31, 2011? _____

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, divorced OR a parent passed away **AFTER** the 2011-2012 FAFSA was completed.

For parent' separated/divorced:

Which parent do you live with? Father Mother

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

For death of a parent:

Date of death: _____ (month/year)

Surviving parent: Father Mother

Complete Section B and attach an 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 2010 for medical and dental expenses. Do not include amounts reimbursed by insurance.

Total Paid to Date in 2010: \$ _____ Total Expected to be Paid in 2011: \$ _____

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

5. One-time Source of Capital Gain or Distribution

Amount of Capital Gain or Distribution Received in 2010? _____

Attach documentation of distribution (copy of settlement, Form 1099, etc.) Attach documentation of expenses paid by distribution, if applicable.

6. Private Secondary Student Expenses (Not College Tuition)

Number of Children in Private School? _____

2010 Out of Pocket Costs? _____

Attach a letter explaining the reason for these out of pocket costs. Most often these expenses are for a sibling of the Eastman student that is enrolled in a private school due to specialized services not available in a public school setting.

Section B: 2011 Projected Income/Expenses

ENTER "0" OR "N/A" WHERE APPROPRIATE. DO NOT LEAVE ANY ITEM BLANK.

TAXABLE INCOME	Actual Amount (January 2011 to present)	Estimated Amount (Present – December 2011)	Total Amount (Add actual and estimated values)
Wages, Salaries, Tips	XXXX	XXXX	XXXX
Student			
Spouse (if applicable)			
Father/Stepfather			
Mother/Stepmother			
Interest and Dividend Income			
Net Income/Loss from Business/Farm (Reported on Schedule C or Schedule F)			
Unemployment Benefits			
Severance			
Capital Gain/Loss (reported on Schedule D)			
Rental Income/Loss (reported on Schedule E)			
Taxable Portions of Social Security			
Taxable Portions of Pension/Annuity Withdrawals			
Income from Royalties, Partnerships, Estates, Trusts			
Alimony Received			
Other Taxable Income:			
UNTAXED INCOME			
Social Security/ SSI benefits			
Public Assistance (ADC, TANF, WIC, etc.)			
Child Support Received			
Disability Benefits			
Voluntary Contributions to Retirement Plans (i.e. 401(k), 403(b))			
Veteran's Benefits			
Housing Allowance (military and clergy)			
Other Untaxed Income:			

If the Sections provided do not allow you to fully explain the circumstances for this appeal, please attach a supplementary letter to provide additional information describing the basis for your request. Attach additional pages and documentation as necessary.

Section C: Physician's Certification

Instructions for physician: You are being asked to complete and sign this form to certify that _____
(name of patient)

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 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, attend school or required continuous nursing 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 the Eastman School of Music has the authority to verify all information reported on this document.

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:

**FINANCIAL AID OFFICE, EASTMAN SCHOOL OF MUSIC
26 GIBBS STREET, ROCHESTER, NEW YORK 14604**

FOR OFFICE USE ONLY: _____ APPROVED _____ DENIED

SIGNATURE _____ DATE _____