

# 2019-20 Financial Aid Appeal Application MD Program

1300 York Avenue  
Room C-114  
New York, NY 10065  
T: 646.962.3479  
F: 212.746.5981

Student Name: \_\_\_\_\_ Student CWID: \_\_\_\_\_

Class year:     YR 1    YR 2    YR 3    YR 4    YR 5

Complete this application and return to our office with the additional documentation requested, if required. The Appeal Application will not be eligible for review until all documentation is received. Under certain conditions, an "Income, Expense and Benefit Worksheet" must also accompany this request.

Parent 1 Name: \_\_\_\_\_ Parent 1 Phone: \_\_\_\_\_ Parent 1 E-mail: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_ Parent 2 Phone: \_\_\_\_\_ Parent 2 E-mail: \_\_\_\_\_

Check	Reason for Appeal	Required Documentation
<input type="checkbox"/>	<p>Significant loss of income due to termination or change in employment</p> <p>Please note: *changes may not be considered if income loss is not significant</p> <p>*you must notify the Office of Financial Aid if you become re-employed before the end of the fiscal year.</p>	<p>Termination or change of employment:</p> <ul style="list-style-type: none"> <li>▪ Federal tax return for year in which income change occurred</li> </ul> <p>Termination or reduction to untaxed benefits, including Social Security, child support, disability:</p> <ul style="list-style-type: none"> <li>▪ Documentation of reduction</li> <li>▪ Explanation for change from granting authority</li> </ul>
<input type="checkbox"/>	<p>Unexpected life event</p> <p>*Note that in a divorce situation, we will continue to consider both custodial and noncustodial parents; income and asset information.</p>	<p>Death of parent of other immediate family member:</p> <ul style="list-style-type: none"> <li>▪ Documentation of medical and/or funeral expenses</li> <li>▪ If decrease in income complete the Income, Expense and Benefit Worksheet (attached)</li> <li>▪ Documentation of expected Social Security benefits for all family members</li> <li>▪ Documentation of other distributions from inheritance, assets, or other benefit sources including life insurance</li> </ul> <p>Divorce/Separation:</p> <ul style="list-style-type: none"> <li>▪ Documentation of second household expenses</li> <li>▪ Listing of child support and/or alimony expected to be paid and/or received</li> </ul>
<input type="checkbox"/>	<p>Correction to income or asset information reported</p>	<ul style="list-style-type: none"> <li>▪ Detailed description of error or correction <u>and</u> all supporting documentation</li> </ul>
<input type="checkbox"/>	<p>High medical or family expenses</p> <p>*expenses must pertain to most recent tax year</p>	<p>Medical:</p> <ul style="list-style-type: none"> <li>▪ Documentation of medical bills paid during prior tax year. if there is an ongoing condition, please provide documentation and/or estimate of treatment costs</li> </ul> <p>Family:</p> <ul style="list-style-type: none"> <li>▪ Documentation of support to relatives outside of the immediate family (cancelled checks, wire transfer records, statement from recipient indicating amount received, etc.)</li> </ul>
<input type="checkbox"/>	<p>Other reason not listed</p>	<ul style="list-style-type: none"> <li>▪ Provide detailed description of the basis of appeal and documentation supporting your request for consideration</li> </ul> <p><u>Note:</u> We are unable to consider appeals based on circumstances that include but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ High consumer debt</li> <li>▪ Personal expenses (pets, cars, housekeepers, vacation, sports, etc.)</li> <li>▪ Expenses that have not yet occurred</li> </ul>

**Student/Parent Certification**

*Signature required by either parent or student*

I/We understand that, as of the date this application is signed, the information included herein is true and accurate to the best of my/our knowledge and is not falsely represented.

I/We understand that the submission of an appeal does not release the student from the obligation of staying current with the Student Accounting bill. I/We understand that as there is no guarantee that an appeal will be approved, it is the student's responsibility to maintain good standing with the Student Accounting Office.

I/We affirm that the information provided on this form and attached documentation is accurate and complete to the best of our knowledge. I/We understand that completing this form does not guarantee financial aid will be increased. I/We also understand that any revision based on this appeal information does not guarantee the same adjustments will be made in future semesters and/or academic years.

I/We understand the appeal will be reviewed within 7-10 business days of receipt by the Financial Aid office and that additional processing time may be necessary in the event more information is requested. I/We understand the parent and/or student may be notified via e-mail with the outcome of the appeal decision.

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SIGNATURE OF STUDENT

DATE

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SIGNATURE OF PARENT(S)

DATE

**Please return completed form with required documents to the Financial Aid Office, 1300 York Avenue, Room C-114  
or email to: [finaid@med.cornell.edu](mailto:finaid@med.cornell.edu)**