



## 2026-2027 SPECIAL CONDITION REQUEST FORM

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|           |            |                   |
|-----------|------------|-------------------|
| Last Name | First Name | Student ID Number |
|-----------|------------|-------------------|

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|               |             |              |
|---------------|-------------|--------------|
| Email Address | Home Phone# | Cell Phone # |
|---------------|-------------|--------------|

### Certification:

*I certify that all the information provided below is true and complete to the best of my knowledge and that I have not purposely given false or misleading information. The required documentation is included to support my request.*

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Student's signature

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Date

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Parent's signature (Required for dependent students) Date

Complete this form if your family has unusual circumstances not reflected on your 2026-27 Free Application for Federal Student Aid (FAFSA) or if your family's financial situation has changed significantly. The Financial Aid Office will review this form and the supporting documents you provide to determine if we can consider your request. If your special condition request is approved, your eligibility for aid may or may not change. Indicate the reason for your special condition request.

- **Base Tax Year Change** – Your family's 2025 taxes more accurately reflect your family's financial situation than your 2024 taxes. Provide 2024 IRS Tax Return Transcripts (available from [www.irs.gov/transcripts](http://www.irs.gov/transcripts) after taxes have been filed) or W-2s for non-tax filers who worked.
- **Involuntary loss of employment or reduction of wages** - A parent, whose income is reported on FAFSA, has lost his or her job and or had a significant reduction of income. Provide a letter from employer showing loss of income was involuntary, final paystub showing year-to-date earnings, and a print-out of unemployment benefits received to date or denial of unemployment benefits.

[Also complete table on the next page]

| 2026-27 Income Estimation Table                                                                | Source of Income | Parent 1 | Parent 2 |
|------------------------------------------------------------------------------------------------|------------------|----------|----------|
| Annual Earnings                                                                                |                  |          |          |
| Other taxable income (interest, dividends, alimony, pensions, unemployment compensation, etc.) |                  |          |          |
| Total Income                                                                                   |                  |          |          |

- **Loss of benefits or support** – Provide a letter from appropriate state or federal agency or other legal documentation specifying total amount of benefits or support received and termination date.
- **Divorce or separation of parents** - Since filing the FAFSA, your parent has divorced or separated. Provide court documentation verifying the legal separation or divorce. If not legally separated, provide documents (lease/rental agreement and utility bills) showing separate residences.
- **Death of a parent** - A parent, whose income is reported on FAFSA, has passed away. Provide a copy of the death certificate.
- **Medical expenses beyond insurance coverage in excess of 10% of adjusted gross income** – Please complete the table below and provide supporting documents (explanation of benefits from insurance provider and receipts for payment). Only report the amount that has already been paid in the last column. Include a separate page if needed. ☐

| Patient's Name                                  | Date of Service | Total Medical Charge | Amount Insurance Paid | Amount Patient/Family Has Paid |
|-------------------------------------------------|-----------------|----------------------|-----------------------|--------------------------------|
|                                                 |                 |                      |                       |                                |
|                                                 |                 |                      |                       |                                |
|                                                 |                 |                      |                       |                                |
|                                                 |                 |                      |                       |                                |
|                                                 |                 |                      |                       |                                |
|                                                 |                 |                      |                       |                                |
|                                                 |                 |                      |                       |                                |
| Total Amount of Medical Expenses Paid by Family |                 |                      |                       |                                |

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### Financial Aid Office Use Only

|                                                     |                                                   |
|-----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Special Condition Approved | <input type="checkbox"/> Special Condition Denied |
|-----------------------------------------------------|---------------------------------------------------|

FAA Signature: \_\_\_\_\_ Date: \_\_\_\_\_