MOUNT ST. MARY'S UNIVERSITY

OFFICE OF FINANCIAL AID
16300 OLD EMMITSBURG ROAD
EMMITSBURG, MARYLAND 21727

301.447.5207
FAX: 301.447.5915
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MEDICAL EXPENSE FORM 2020-21 Academic Year

Please check one of the following ☐ Continuing Student ☐ New Student

_____ _____
Applicant's Name Applicant's MSM ID or SSN

The purpose of this form is to report extraordinary medical expenses paid in calendar year 2019 for family members. Complete the worksheet below to determine if this form should be submitted.

Total amount **actually paid in 2019 for unreimbursed** medical dental and vision care expenses. Include paid insurance premiums. Do not include amounts covered by insurance, company medical reimbursement account (flexible spending account), or self-employed health deductions. 1. $_____

Adjusted Gross Income reported on 2019 Federal Tax Return 2. $_____

Multiply line 2 by .10 and enter answer on line 3 3. $_____

Subtract line 3 from line 1. If line 4 is less than zero, stop. You are not eligible to submit this form. 4. $_____

If line 4 is greater than zero, read and sign the certification below form. If you completed 1040 Schedule A, attach to this form.

I attest that the above information is accurate. Furthermore I (we) understand that the above data will be used to determine eligibility for Federal and Mount St. Mary's financial assistance and is subject to verification by Mount St. Mary's University.

Applicant's Signature_____ Date_____

Spouse's Signature (*if married*)_____ Date_____

Father's Signature_____ Date_____

Mother's Signature_____ Date_____

Complete this form only if it applies to you. Return to:
Financial Aid Office
Mount St. Mary's University
Emmitsburg, MD 21727
Fax: 301-447-5915
Phone: 301-447-5207