2024-2025 Special Circumstances–Unusual Medical/Dental Expenses Paid

Student Name: _____ Student ID: _____

By signing below, I authorize Mayland Community College to make the applicable changes electronically on my behalf. I further understand this may change federal or state aid I was previously awarded.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

(Required for dependent students)

You have indicated there are circumstances that may affect the results of your Free Application for Federal Student Aid (FAFSA). Please follow instructions and submit all required documentation listed on the next page.

Instructions:

- Provide **all** documentation listed below. ***Incomplete applications will not be reviewed or considered.***
- The student must provide a written statement to detail the circumstance(s) that are causing this request to be submitted. A parent may also submit a statement, but it will not replace the requirement of a student statement.
- Additional documentation may be provided as well, if the student/family feels it is relevant to the request.
- Requests are reviewed as they are received, however, review and processing of these requests may take 3-5 business days.
- Once you submit your request, check your MCC student Gmail email *often,* as this is how the MCC Financial Aid Office will communicate with you.
- Please contact the MCC Financial Aid with any questions you have about completing this form and your specific circumstances.

**after FAFSA was completed*

Mayland Community College
200 Mayland Drive | Spruce Pine, NC 28777 | 828.766.1204 *tel.* | Finaid@mayland.edu

2024-2025 Special Circumstances–Unusual Medical/Dental Expenses Paid

Student Name: _____ Student ID: _____

Relationship to the student (self, mother, father, etc.): _____

Required Documentation:

- Written statement from student outlining the circumstances
- **Signed** copies of **2022** and **2023** federal tax returns, including **all** W2 form(s), 1099 form(s)*, and Schedules*
    - **if applicable*
- Verification of 2024 year-to-date earnings (i.e. pay stub)
- Statement(s) from medical providers showing amounts **paid** in 2022 and 2023 (if both years are applicable)
- Statement(s) from medical providers showing amounts outstanding after payments were made

By signing below, I attest that all information is true and accurate to the best of my knowledge. Further, I understand that additional information may be requested as a part of this review process and that incomplete applications will not be reviewed or considered.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

(Required for dependent students)

**after FAFSA was completed*

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