



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

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## MEDICAL EXPENSE FORM 2011-12 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 2010 for family members. Complete the worksheet below to determine if this form should be submitted.

Total amount **actually paid in 2010 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 2010 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 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**