



TGME 09

09B10-1/09

State Grant and Special Programs
Phone: 1-800-692-7392 Fax: 717-720-3786

2009-10 MEDICAL EXPENSE FORM
(DEPENDENT STUDENT)

(NOTE: Deadline for returning this form and 2008 tax documents to PHEAA is April 1, 2010.)

Print Student's Name

Student's Social Security Number grid

Student's Social Security Number

OR

Student's Account Number grid

Student's Account Number

2009-10

The Agency may permit reconsideration of an application if your family paid extraordinary unreimbursed medical/dental expenses during 2008. Your parent(s) should provide the requested information regarding family medical/dental expenses to PHEAA, P.O. Box 8141, Harrisburg, PA 17105-8141 within 30 days. No data will be accepted after April 1, 2010.

Submit a complete copy of your parent(s)' 2008 U.S. Income Tax Return (as filed with IRS) including all supporting forms, schedules, and W-2 Forms, if such has not previously been submitted, and this form which aids in the immediate identification of your records. Each W-2 Form should contain figures in Box 1 and either Box 16 or Box 18. If your parent(s) have an interest in a corporation and/or partnership you also need to submit copies of the most recent U.S. Partnership and/or Corporation Tax Return(s), including the completed balance sheet(s) and K-1 schedule(s). If your parent(s) itemized medical expenses on Schedule A, you should also submit a copy of Schedule A. If your parents(s) did not file or did not retain a copy of Schedule A, they should complete the following questions. Do not send copies of receipts or cancelled checks.

If you have any questions regarding this matter, please contact Agency staff at 1-800-692-7392 (TDD for hearing impaired ONLY: 717-720-2366).

- 1. Indicate the amount of money which your parent(s) PAID in 2008 for medical and dental expenses (including insurance premiums). Do not include amounts covered by insurance, your company pre-tax medical/dental reimbursement account (flexible spending account), monies paid toward establishing the company medical reimbursement account if tax-deferred, or self-employed health deductions from Form 1040 - line 29.

\$ _____

- 2. Indicate whether your family medical/dental expenses were paid from income, savings, and/or other sources and indicate the approximate amount paid from each source.

Blank lines for source and amount information

THE PENALTY FOR SUBMISSION OF FRAUDULENT INFORMATION ON THIS FORM MAY BE REPAYMENT OF TRIPLE ANY AMOUNT OF MONEY RECEIVED PLUS A FINE AND/OR IMPRISONMENT.

Signature of Parent/Stepparent Date

Signature of Student Date

